May 1961

Mental Hospitals

Hospital Journal
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pg. 26

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Mental Hospitals

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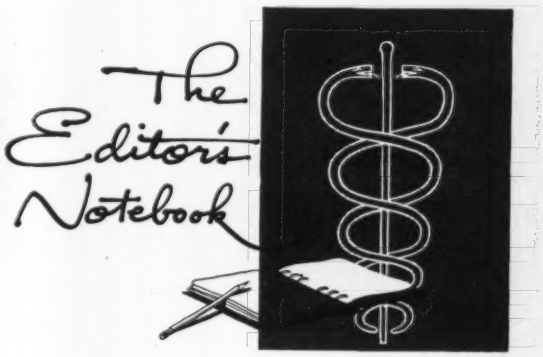

THE COUNCIL OF THE AMERICAN PSYCHIATRIC ASSOCIATION recently released the following official statement of policy on confidentiality:

"Confidentiality may be defined as an ethical understanding between the physician and the patient that anything the patient tells his doctor will not be divulged to anyone else. The principle has governed physician-patient relationships since time immemorial and is as sound today as ever. In the case of psychiatry, it is absolutely essential to the practice of psychotherapy, since, obviously, patients would not reveal their thoughts and feelings if it were not observed.

"Confidentiality, however, like freedom, is not quite absolute. The physician, like everyone else, is subject to laws which may, under certain circumstances, require a breach of the rule of confidentiality. Even then, however, there are certain legal procedures which must be scrupulously followed. In addition there is a vaguer area in which the physician must, in the last analysis, turn only to God and his own conscience for guidance as when an act harmful to the patient and society might be committed if strict confidentiality were to be maintained. The rare exception, however, only reinforces the time-honored rule."

I quote this statement here because I believe that, while it is directed to physicians, it has broad implications for everyone who works with mental patients. How confidential, for instance is the information which a patient reveals to his social worker, to the nurse on the ward, to the aide who accompanies him on his walk around the hospital grounds? What is the medical records librarian's responsibility in regard to confidentiality? What responsibility does the psychologist or the electroencephalographer or the laboratory technician have to keep confidential the information he receives from tests? There is, of course, a great need for members of a treatment team to exchange information for the benefit of the patient. But where does this exchange cease to be therapeutic and become mere gossip, constituting a breach of confidentiality?

The problem of confidentiality even arises in group psychotherapy; privileged communication should exist between all members of the group, but this would be a departure from the legal position of limiting such privilege to the relationship between two persons. This "legal position" is anything but clear. Most patients assume that they are protected by privileged communication in their doctors' offices or in hospital settings. Unfortunately, while such privilege exists between priest and parishioner, lawyer and client, it is only a qualified right between doctor and patient.

Under existing laws the boundary lines of confidentiality in our medical specialty can sometimes be as amorphous for both doctor and patient as are those of outer space when nations dispute their rights to the cosmos. But every hospital staff member must be aware of these legal ambiguities, and recognize his moral responsibility to protect the patient to the best of his ability. He must remember, too, that the right of privilege, whenever it exists, belongs to the *patient*, and not to the doctor or the hospital.

Confidentiality is a subject of vital concern to all of us. It is apt to become more so in this age of increasing legal technicalities and complexities. The crux of the matter is that we all are often caught between our responsibility to our patients and our responsibility to society.

As editor of Mental Hospitals I would like to take this opportunity to solicit articles, letters, or short, written observations on this subject.

Matthew Ross, M.D.

'Thorazine'
Psychiatric Prescribing Information

ADULT INDICATIONS AND DOSAGE

Dosage should always be adjusted to the response of the individual and the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become excessively troublesome.

Mental and Emotional Disturbances of Everyday Practice—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals (increase should be more gradual in emaciated or senile patients) until achieving maximum clinical response. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but in some cases, such as discharged mental patients, daily dosages as high as 800 mg. may be necessary. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Hospitalized Psychiatric Patients—*Acutely agitated, manic, or disturbed patients: Starting intramuscular dose* is 25 mg. (1 cc.). If no marked hypotension occurs, an additional 25 mg. to 50 mg. injection may be given after one hour. Subsequent intramuscular dosages may be increased gradually over a period of several days—even up to 400 mg. q4-6h in exceptionally severe cases—until the patient is controlled. (In elderly or emaciated patients the dosage should be increased more slowly than in other patients.) Usually the patient becomes quiet and cooperative within 24 to 48 hours after the initial dose, at which time oral doses may gradually be substituted for intramuscular doses (mg. for mg. or higher). Even if control is not complete, oral doses may gradually replace intramuscular doses. During this period, oral dosage should be increased rapidly until the patient is calm. Usually an *oral dose* of 500 mg. a day is sufficient but, if necessary, the dosage may be gradually increased still further to 2,000 mg. a day or higher. *Less acutely agitated patients: Starting oral dose* is 25 mg. t.i.d. Subsequently, increase the amount gradually until an effective dosage is reached—usually 400 mg. daily is sufficient. *Duration of therapy:* It is important to determine the optimal dosage regimen and to continue treatment long enough for maximum clinical response. Maximum improvement is sometimes not apparent until after weeks or even months of therapy.

Alcoholism—*Starting intramuscular dose* for severely agitated patients is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. *Starting oral dose* for agitated but manageable patients is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

PEDIATRIC INDICATIONS AND DOSAGE

For behavior disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day. In children 5-12 years (or 50-100 lbs.)—nor over 75 mg./day. In *severely disturbed cases*, 50-100 mg. daily has been used, and, in older children, 200 mg. or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery. Because contact dermatitis has been reported, avoid getting the solution on hands or clothing.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' may be unwanted in some patients. It is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects that have been reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

During 'Thorazine' therapy some patients have an increased appetite and gain weight. Usually these patients reach a plateau beyond which they do not gain further weight.

CAUTIONS

Jaundice: In the more than 14 million patients who have been treated with 'Thorazine' in the United States, the incidence of jaundice—regardless of indication, dosage, or mode of administration—has been low. Few cases have occurred in less than one week or after six weeks.

Jaundice due to 'Thorazine' is of the so-called "obstructive" type; is without parenchymal damage; and is usually promptly reversible upon the withdrawal of 'Thorazine'.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported in patients on 'Thorazine' therapy. Patients receiving 'Thorazine' should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted. Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells is sometimes observed in patients on 'Thorazine' therapy. If not accompanied by other symptoms, it is not an indication for discontinuing 'Thorazine'.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants, such as barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If it is desirable to administer a vasoconstrictor, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Causes of Vomiting: The physician should always bear in mind that the antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some of them appear to be due to photosensitivity, and it is advisable that patients on 'Thorazine' avoid undue exposure to the summer sun.

Extrapyramidal Symptoms: With very large doses of 'Thorazine', as frequently used in psychiatric cases over long periods, there have been a few patients who have exhibited extrapyramidal symptoms which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug withdrawn. These symptoms can also be controlled by the concomitant administration of standard anti-parkinsonism agents.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This, however, is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

In comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.), and also in patients under the influence of large amounts of barbiturates or narcotics.

AVAILABLE

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains chlorpromazine hydrochloride, 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, chlorpromazine hydrochloride, 25 mg.; ascorbic acid, 2 mg.; sodium bisulfite, 1 mg.; sodium sulfite, 1 mg.; sodium chloride, 6 mg.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, chlorpromazine hydrochloride, 25 mg.; ascorbic acid, 2 mg.; sodium bisulfite, 1 mg.; sodium sulfite, 1 mg.; sodium chloride, 1 mg. Contains benzyl alcohol, 2%, as preservative.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains chlorpromazine hydrochloride, 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains chlorpromazine hydrochloride, 10 mg.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains chlorpromazine, 25 mg. or 100 mg.; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles. (Each cc. contains chlorpromazine hydrochloride, 30 mg.)

Before prescribing 'Thorazine' in any indication other than those given here, the physician should be familiar with dosage, side effects, cautions and contraindications for such indications. This information is available in: *Thorazine® Reference Manual* and *Physicians' Desk Reference.*

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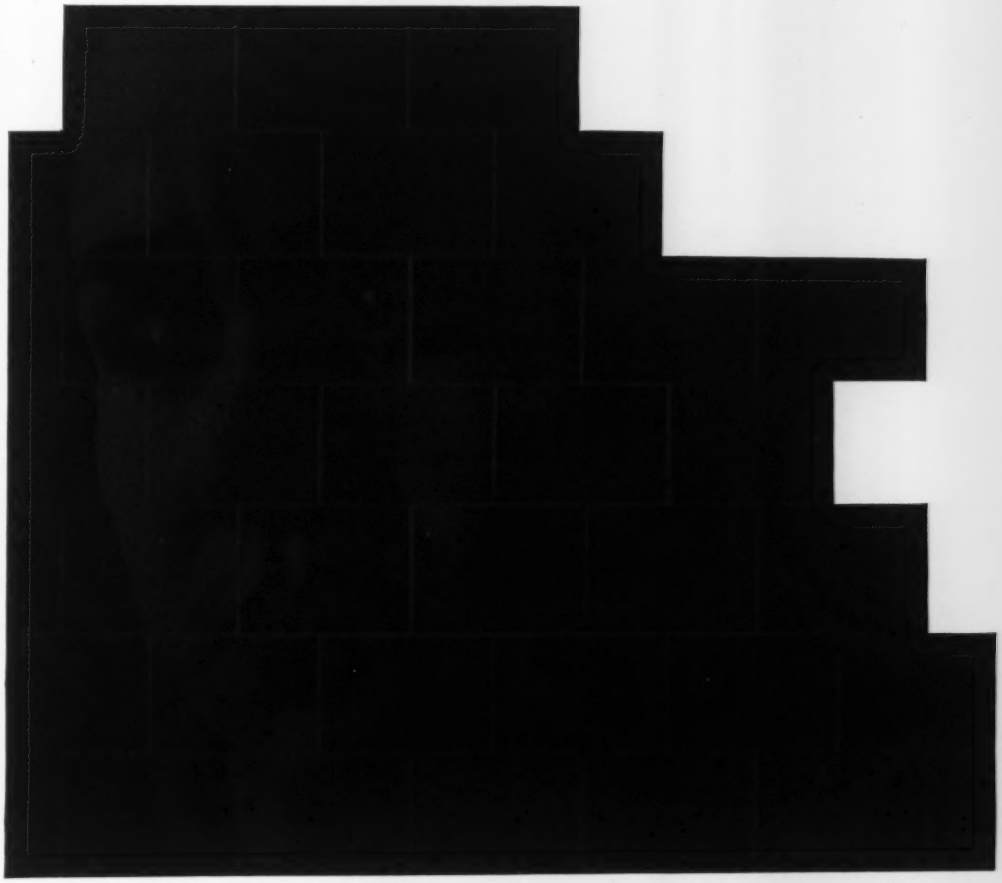

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Clinical Nurses as Teachers

By EDWARD N. HINKO, M.D., *Director*
and IRA FRIEDMAN, Ph.D., *Chief Psychologist*
Cleveland Psychiatric Institute and Hospital, Ohio

PLANS ARE DRAWN ON PAPER. When they involve people rather than inanimate objects, their successful fruition requires sensitive handling of human relations as well as application of sound principles of scientific administration. Outlining objectives and developing techniques for implementing the plans are only the beginning. Inadequate consideration of the people involved—their needs, interests, motivations, personalities, and the like—frequently results in the failure of the best laid plans. On the other hand, when the situation is structured to permit personnel to discharge organizational requirements and satisfy individual needs at the same time, the stage is set for optimal satisfaction and performance.

This paper is an account of the evolution of a program of psychiatric nursing education, with particular focus on clinical instruction. Our purpose is to describe the approaches we used in dealing with problems which emerged in the course of the evolution. Since the program involves clinical nurses, nursing instructors, and student nurses, as well as other staff, a great many of these problems were in the area of human relations.

For many years the Cleveland Psychiatric Institute and Hospital had been involved in a paradoxical situation. It maintained an affiliation in psychiatric nursing, but responsibility for the education of nursing students remained with the adjacent Cleveland Metropolitan General Hospital and its school of nursing. The students were directly responsible to the nursing education staff employed by CMGH, but received the major part of their clinical supervision from the CPI&H nursing staff.

Throughout the years this situation led to some confusion. The students had problems in institutional identification, not feeling truly a part of either institution. They were uncertain about supervision, since a good part of the time they were under the direction of CPI&H nurses, while CMGH nursing faculty organized and conducted their didactic programs and gave out their grades. Similarly, the CMGH nursing faculty maintained offices at CPI&H, and had a variety of administrative superiors to whom they were responsible. All in all, it was an unhealthy situation.

Our main problem, once recognized, dictated its own solution. Administrative efforts were geared to eliminate the duality of responsibilities, authority, and iden-

tification. On July 1, 1959, the Ohio Department of Mental Hygiene and Correction contracted to assume total responsibility for an affiliation in psychiatric nursing to be conducted at the Cleveland Psychiatric Institute and Hospital. This administrative action eliminated the problems of dual affiliation and resulted in a variety of gratifying benefits. However, the new organizational structure brought its own problems.

THE PROBLEM OF CLINICAL INSTRUCTION

The Ohio State Board of Nursing requires that students have at least two hours of planned clinical instruction per week during the 13-week psychiatric affiliation. CPI&H had been functioning with only two full-time nursing instructors, who were carrying a variety of administrative responsibilities in addition to planning, preparing, organizing, and conducting formal didactic classes. It was obviously impossible for two instructors to provide the required clinical instruction for 70 student nurses assigned to ten different wards. Several alternative plans were considered:

(1) To combine nursing student teams from different wards in the two-hour ward conferences each week. The major advantage of this plan would be in terms of availability of time of nursing instructors. The major disadvantage would be that many of the patients discussed would be unknown to some of the students, and this would seriously reduce benefits derived from such instruction.
(2) To hire additional nursing instructors to handle the large teaching assignment. This plan tends to be impractical since there is a scarcity of trained psychiatric nursing instructors.
(3) To transfer several members of the clinical nursing staff to the nursing faculty. This would serve to meet the teaching requirement but would reduce clinical nursing services, unless other clinical nurses could be employed.
(4) To utilize clinical nursing staff in clinical instruction while maintaining them as clinical nurses. This would have the dual advantage of reducing the teaching burden on all and allowing the students to discuss patients with experienced nurses who knew the patients. The major disadvantage would be in the limited teaching skills of the clinical nurses.

The last plan appeared to hold the most promise, particularly if nursing instructors and some nursing supervisors could assist the clinical nurses in the development of teaching skills and procedures.

RELEVANT INTRAPERSONAL VARIABLES

The decision to involve graduate psychiatric nurses in the clinical training of students is an example of a paper plan. While well-conceived in many respects, it is capable of being a dismal failure if those entrusted with the responsibility of carrying it out are not sufficiently motivated to assume the responsibility. In order to implement this plan and to motivate our nursing personnel, we first undertook to understand the nurses and to make the program fit their needs. Then we presented the plan in ways designed to bolster their positive feelings.

The educational backgrounds of the Cleveland Psychiatric Institute and Hospital staff nurses differ widely. Most of the nurses graduated from three-year programs. Some of them have had college training, some are presently enrolled in a university program on a part-time basis, and others have earned a degree. Most of them have had considerable psychiatric experience, which they can utilize with varying degrees of effectiveness in teaching young, inexperienced students.

A common complaint of the psychiatric nurse is that she is overwhelmed with detailed administrative work. As a consequence, she believes she has little time for any task in addition to the one she is currently doing. However, one cannot help but wonder if this attitude manifests the nurse's feeling of reduced self-importance; perhaps she unconsciously compensates by gaining a sense of importance from her belief that she is swamped with work. Furthermore, many older nurses with years of experience feel insecure about their lack of formal training, and are reluctant to enter into a situation where they may expose a lack of knowledge about newer approaches in psychiatric nursing. Their complaints about new methods and new students are, in part, a cover for these unwarranted feelings of insecurity, and they often regard the nursing student as a threat and a rival. In any event, it seemed worthwhile to approach the problem of motivating the clinical nurse by techniques which would enhance her feelings of importance and help to reduce her feelings of inadequacy, without threatening her self-esteem.

As a first step, we held a planning meeting of head nurses and nursing instructors. While the obvious goal of this meeting was to outline the new program, a major but somewhat subliminal purpose was to alter feelings, perceptions, and motivations of the head nurses in order to secure their wholehearted cooperation. Techniques used in the meeting were as follows:

1) *Catharsis*—We gave the head nurse opportunity to freely express feelings, to complain, etc. The director of nursing and the nursing instructors listened sympathetically.

2) *Elimination of Defensive Rationalizations Without Interpretation*—We dealt with complaints by attempting to correct causes for real grievances rather than to interpret all of them as defensive mechanisms to avoid involvement in the new teaching program. Head nurses complained most frequently that they were too busy, that library facilities were inadequate, and that facilities for conducting the classes on the ward were poor. Accordingly, we made suggestions for reorganizing and delegating ward duties to allow the nurses to devote more time to the teaching program; we provided a large library in the research wing of the hospital, and added appropriate books, including personal textbooks of nursing instructors; we made conference rooms and classrooms in the research wing available to the nurses for ward conference use. This technique

eliminated defensive rationalization, but increased anxiety because it brought the real reasons closer to awareness. As a consequence, other approaches were utilized to reduce anxiety and strengthen the ego.

3) *Role Structuring*—In the process of providing nursing service through the years, the psychiatric nurse builds a role-conception which does not include that of a teacher. For this reason we stressed the teaching function as a legitimate and desirable one for the psychiatric nurse.

4) *Reduction of Ambiguity*—In order to prevent the nurses from feeling uncertain and overwhelmed, we stated the formal objectives of the program, developed outlines for conferences, set definite hours for conducting classes, and provided reference lists. However, in order not to restrict those nurses who did not desire such definite structure, we emphasized flexibility as appropriate and encouraged the head nurses not to feel constrained by the outlines and procedures.

5) *Opportunity for Dependency*—The nursing instructors made themselves available for consultation, assistance, and supervision on an individual basis—not as evidence of the teaching ineptitude of the head nurses, but rather as an opportunity for clinical nurses to benefit from the teaching experiences of the nursing instructors.

6) *Ego Support*—In an effort to enhance the self-picture of the head nurses and to increase their confidence in their ability to make a realistic contribution to the program, we pointed out a variety of facts. First, the psychiatric nurse has a wealth of clinical data accruing from extended contacts and experience with many patients. Second, she is familiar with every patient in the unit, and, through contacts with the physician in charge, has knowledge of the treatment plan for each patient, as well as experience in the development of techniques for carrying it out. For these reasons, the head nurse involved in ongoing clinical functions is in the best position to offer practical and realistic clinical instruction to the nursing student. When the student is immediately responsible to the nurse who is directing her activities and guiding her performance in the clinical area, the student develops the feeling that she is an active, contributing member of the team, working toward the health and well-being of the patients.

PROGRAM EVALUATION

Throughout the course of this newly instituted program, the nurses expressed their reactions both informally and formally at meetings. After the program was in operation for one year, we prepared and distributed a questionnaire. We utilized much of the resulting data to institute revisions and additions.

Perhaps the most important finding is related to the over-all reactions of the head nurses to their involvement in the program of clinical instruction. Three fourths of the 20 nurses involved in the program regarded it favorably. They considered it challenging for the graduate, and indicated that the conferences were a profitable learning experience for both graduates and students. Almost all said that they were able to know the students better, to see them more clearly as individuals, to understand their attitudes toward patients and toward psychiatric nursing. They were also able to develop closer relationships among ward staff, which in turn had favorable effects on patients, and to give much more attention to specific problem areas when gaps in knowledge were revealed as students expressed their views and problems.

The five who criticized the program unfavorably expressed the view that the nursing instructors were better prepared to do the job; they felt they were at a disadvantage because of their inadequate training, and complained that there was too much pressure and too few staff members.

FUTURE PLANS

A program of this nature requires continual evaluation. The first year of experience revealed that it is possible to motivate and interest a large segment of clinical psychiatric nurses once initial resistance, anxiety, or inertia is overcome.

However, the five unfavorable reactions to the program highlight the need for greater incentives for all. Attempts must be geared to evaluate whether the failure to motivate these nurses reflects a deficiency in administrative approach, or whether we might reasonably expect a portion of any clinical nursing group to resist involvement in this type of program. Administrative action is of no avail unless members comprising the enterprise are motivated to contribute the effort required in the achievement of the program objectives. The difference between grudging acceptance and enthusiastic participation may well be the difference between failure and success.

We need to know much more about the sources of satisfaction and dissatisfaction in various work situations within the hospital, and particularly about their relationship to effectiveness of employee performance. The improbability of solving, during the next decade, the problem of shortages of personnel, makes it imperative that we give serious consideration to insuring the maximum functioning of the personnel we do have.

There is need for well-defined research to evaluate the potential teaching assets of the nurse who has many years of psychiatric experience but no psychiatric education or training, and whose realistic home and family responsibilities make formal training and education currently infeasible. There is further need to evaluate the most effective methods of developing the assets of these nurses into skills to be utilized in the clinical on-the-ward training of the student nurse.

The authors acknowledge their deep appreciation to Mrs. Helen Kreigh, R.N., B.S., Nursing Instructor, and Miss Joan Weiler, R.N., M.S., Director of Nursing Service, Cleveland Psychiatric Institute and Hospital, for their valuable cooperation and aid in this project.

Talking *it over on a disturbed ward*

By S. E. STEVENS, M.D.
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THE NEVER-ENDING TASKS of the ward psychiatrist, and the impossibility of his ever being able to reach all the patients on his ward individually, prompted the initiation in this hospital of a modified group therapy program conducted by the psychiatric technicians on a ward for disturbed women. The limited goal of the program was to decrease the amount of disturbed behavior by increasing interpatient and patient-staff verbalization.

To this end the ward psychiatrist oriented the psychiatric technicians to the purpose and benefits of the proposed program and explained the technique to be employed. Training devices included lectures, reading lists, meetings, and individual conferences. In general, the goal of the orientation was to teach the technicians to act as group moderators to stimulate interaction among patients. They were instructed to refrain from making authoritarian interpretations of patients' statements, but to feel free to voice an opinion as a member of the group.

Following the orientation period, each technician was asked to select eight to twelve patients of various ages and diagnoses to compose his group. He was to explain to them that the new program would give them an opportunity to express their ideas and share their experiences with each other.

Many of the technicians were skeptical about the program. Their experiences with disturbed patients had given them no understanding of how group interaction could prevent disturbed behavior. However, an incident in an early ward meeting provided the psychiatrist with a dramatic illustration of this basic premise. One of the patients became violently assaultive during the meeting, and the technicians wanted to remove her from the room. Instead, the psychiatrist asked her to sit down and then introduced the subject of fighting as a discussion topic for the group. The assaultive patient sat quietly while a number of the other patients launched a blistering verbal attack upon her behavior. After the subject was thoroughly aired, the meeting was closed. This was the last incident of fighting for that particular patient, and the technicians attending the meeting were impressed with the possibilities of the new technique.

The general format of the program consists of small group meetings at least once weekly under the direction of the psychiatric technicians, a weekly motion picture with a psychological theme, and a weekly ward meeting conducted for all patients by the psychiatrist.

The weekly movie always concerns mental illness and provides discussion material for the small group meetings. During the general ward meeting, the psychiatrist introduces topics concerning mental illness, hospitalization, or administrative problems, and makes announcements about patients who have been discharged or transferred. New patients are introduced, requested to stand, and given a hand-clapping welcome. This meeting is extremely useful in keeping the patients informed about routine matters, obviating the necessity of taking time for these during the smaller group meetings. At the same time, it permits some interaction between the patients and the ward psychiatrist.

TEMPORARY SUCCESS

After the early ward meeting during which the incident of the assaultive patient took place, there was noticeably less fighting among the patients, but verbal expressions of hostility increased. Eventually even these subsided to a considerable degree. The ward became quieter and the patients and personnel more secure.

Unfortunately, this did not last. The pressure of other work assignments and the attitudes of certain personnel produced a laxity regarding the group therapy program, and the "disturbed" atmosphere returned to the ward. The technicians were again exhorted by the ward psychiatrist in a team meeting to devote their efforts to preventing disturbed behavior rather than to taking care of it when it happened. Following this advice, they renewed the program with added vigor and were rewarded by seeing the ward atmosphere again become more normal.

PROBLEMS AND OBSTACLES

The instigation and continuation of such a program on a disturbed ward was not accomplished easily. The technicians' lack of understanding and knowledge was only one of the obstacles to be overcome. The scarcity of their numbers was a major problem, and nearly all ward personnel were assigned to the program to insure maximum patient-participation. Transfer of personnel from the ward was discouraged once the program was under way, and technicians' schedules were adjusted to allow for the group meetings.

The lack of appropriate physical facilities was also a problem. The groups met in dormitories with beds

pushed back, or in any other room which would permit a circular seating arrangement. Outside disturbances were kept to a minimum during the scheduled group sessions.

Resistance by the patients to the program was minimal. Told by the psychiatrist that they must attend the group meetings regardless of whether they felt they had anything to say, the patients accepted the meetings and grew to look forward to them. A few of the more enthusiastic ones tried to become members of more than one group.

TANGIBLE GAINS

The program has produced favorable results beyond its immediate goal of reducing disturbance on the ward. Physical violence is minimal and restraints have been eliminated completely. The seclusion rate has dropped and many more patients receive ground-parole and home-visiting privileges. Some have been discharged directly from the ward.

As harassment by patients diminished, the ward personnel became more relaxed and their morale has increased greatly. They feel they are participating in treatment and not being used just for the custodial care of patients. Several psychiatric technicians from other wards have asked to be transferred to the "disturbed" ward which we unofficially renamed the "active treatment" ward.

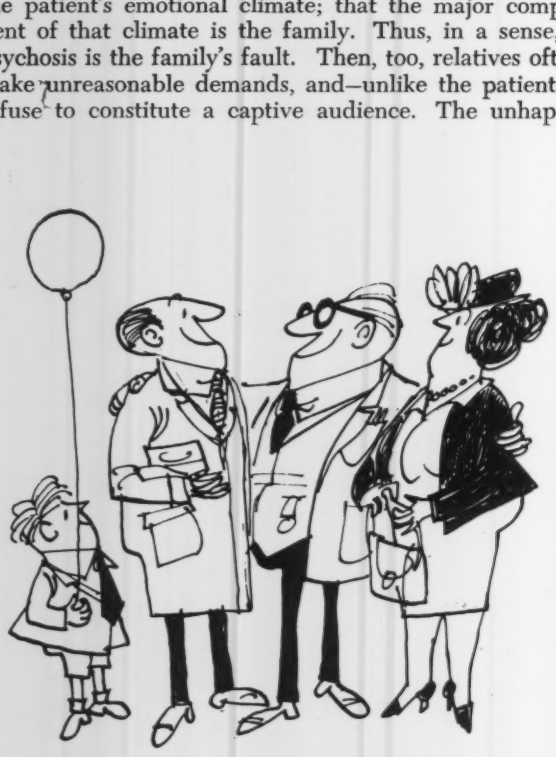
One additional benefit has accrued from the program. Visiting on the ward is permitted at all times and relatives, pleased with the controlled therapeutic atmosphere, are no longer anxious about their patients' placement on a "disturbed" ward. Visitors strange to the program have been heard to ask, "Where are the disturbed patients?"

BE-KIND-TO-RELATIVES WEEK

By Dr. WHATSISNAME

IN THE DRAMA of the mental hospital, the relative is cast in the role of villain. It's a standard gag that the patients are easy—it's their families who give us trouble.

Hostility to relatives is based on several factors. Many of us believe that psychoses are precipitated by the patient's emotional climate; that the major component of that climate is the family. Thus, in a sense, a psychosis is the family's fault. Then, too, relatives often make unreasonable demands, and—unlike the patients—refuse to constitute a captive audience. The unhappy relative is a constant reminder of our impotence to cure mental illness, and we wish he'd go away. Finally, we get some virtuous satisfaction out of saying that an application for commitment is a relative's way of rejecting the patient. This leads to the unspoken but generally accepted dictum that hospital staff personnel would be happier if patients had no relatives.



We often assume that a psychosis is due to the way the family treated the patient. In the intangible, invisible battle between the patient and his relatives we, naturally, are on the patient's side. As with all partisanship, we may be blind to the view from the other side of the bridge.

But there *is* a case for the relative, after all. The decision to commit was reached after miserable soul-searching. The responsible family member staggers under a load of guilt. He has had to reorganize his life. He has been sitting on a dynamite keg. He is torn between relief at the patient's absence from the house and fear of an endless chain of threatening furloughs from the hospital. He is on guard against the queries and complaints of neighbors, friends, and more distant relatives. The latter contumaciously blame him for the whole mess. When he talks with the doctors or the social workers, he realizes that they shape their decisions in terms of what will be best for the patient; that they have no sympathy for relatives who may be embarrassed or troubled as a result of such decisions. He feels that he, too, is entitled to consideration—but he gets very little of it from the hospital when his needs conflict with those of the patient. To make matters worse, he can't even complain about this without appearing to be brutally selfish.

To those of us in hospital work, every day is patient's day. Perhaps we might set aside a few days for meditation on the troubles of the relative.

*II. Clinics, private psychiatrists, and general hospital units must increase their ability to meet present and future demands.

Action For Community Facilities

By JOSEPH T. GRECO
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ONE OF THE MOST SHOCKING FINDINGS of the Joint Commission on Mental Illness and Health is that society on every level—nonprofessional and professional—rejects its mentally ill. The report documents this statement, citing as evidence the fact that major mental illness threatens to be the number-one unsolved problem of the nation; that treatment developments have lagged; that in almost every section of the country there is not only an unmet need but an increasing public demand for better mental health services.

The need and the demand are demonstrated, declares the commission, by the overcrowding of the public mental hospitals; the small amount of service available to expatients still in need of it; the long waiting lists of existing mental health clinics; the difficulty people experience in obtaining professional assistance in a crisis; and, in many communities, the total absence of mental health facilities and workers.

One of the most dramatic achievements of our time has been the improvement in general medical and surgical care, and the consequent improvement in the health level of Americans. Against these achievements, the lack of advances in the treatment of mental disease with a corollary improvement in the mental health of the population stands out darkly. True, there have been many gains for instance, in intensive psychotherapy, in chemotherapy, in newly-designed facilities, and in improved public attitudes. The Joint Commission, however, evaluated our new approaches qualitatively, exploring assumptions upon which treatments are based—and found our efforts sadly lacking. By this type of analysis, the commission tried to indicate the basic problems and issues that we must face before we can find solutions.

The commission concluded that a national program is needed to attack the problems constructively. The main unanswered question is that of adequate financing, and the commission boldly proposes sweeping changes of policy in the form of massive Federal support along with greatly increased state appropriations. Adequate financing will to a large degree determine whether or not the benefits of already-existing knowledge will be made available to all in need, regardless of their socioeconomic group, and regardless of how long treatment must continue. And, in long-term goals, Americans must also decide whether it is proper for their tax money to be spent in seeking greater knowledge about effective cure and rehabilitation through continued research, evaluation, and investigation.

The primary intent of this paper is to review the findings and recommendations of the commission as they relate specifically to mental health clinics and private patient care, to emergency service and secondary prevention, and to psychiatric units in general hospitals. These three areas are very closely associated with the general community, and may be expected to grow in importance during the next decade. It is projected that the population of the United States within the next ten years will approach 200 million people, and that approximately ten per cent of that population—a staggering 20 million—will need or could at least be helped by psychiatric assistance in one form or another. Studies of modern treatment trends suggest that we may expect that an even larger proportion of the patient's time, while undergoing active therapy, will be spent *outside of long-term hospitals.* This larger portion of treatment time will be spent either with the family or at least with other natural community groups. Certainly present evidence, sketchy though it may be, indicates that the prospect for recovery and successful rehabilitation increases when the patient's home and the place where he receives treatment are in close proximity. Thus it is urgent that we evaluate sternly the contributions demanded from clin-

**This is the second of a series of articles on "Action for Mental Health," the final report of the Joint Commission on Mental Illness and Health. The series is sponsored by the Program Committee for the 13th Mental Hospital Institute, and is intended as orientation material for the Institute discussions.*

ics, private psychiatrists and other physicians, and the psychiatric units in general hospitals. Unquestionably many changes in existing policies and procedures will be involved in any national effort, and in the final analysis, problems will have to be solved on the various local levels.

CLINICS AND PRIVATE PATIENT CARE

RECOMMENDATION: "Community mental health clinics serving both children and adults, operated as outpatient departments of general or mental hospitals, as part of State or regional systems for mental patient care, or as independent agencies, are a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization. Therefore, a national mental health program should set as an objective one fully staffed, full-time mental health clinic available to each 50,000 of population. Greater efforts should be made to induce more psychiatrists in private practice to devote a substantial part of their working hours to community clinic services, both as consultants and as therapists.

"The principal functions of a mental health clinic serving adults (the majority serve both adults and children) should be: (1) to provide treatment by a basic mental health team (usually psychiatrist, psychologist, and social worker) for persons with acute mental illness, (2) to care for incompletely recovered mental patients either short of admission to a hospital or following discharge from the hospital, and (3) to provide a headquarters base for mental health consultants working with mental health counselors. The function of such a clinic as a center of mental health education for the public is of incidental importance, and should preferably be left to other agencies."

Against the commission's recommendation, today's facilities look sparse indeed. Less than one fourth of the nation's counties have a mental health clinic; those which do exist are plagued with man-power shortages as severe as those experienced by other mental health facilities. Like state hospitals, clinics are overcrowded, even though their surplus patients are recorded, untreated, on waiting lists, instead of vegetating, untreated, on back wards. In an endeavor to deal with this ever-lengthening waiting list, the clinics set up their own criteria for admission: patients will be accepted or rejected on the basis of age, diagnosis, type of problem, ability to pay, place of residence, and even social standing. Nor is overspecialization uncommon among professional clinic staffs —probably stemming from an attempt to screen out the less potentially rewarding applicants. The result, however, has been for clinics to function in isolation from one another and from local, regional, or state inpatient facilities.

It is not surprising, then, if there appears to be a lack of control or coordination of the operation of community clinics, and that policies are not always clear and consistent. Once admitted for treatment, the amount of therapeutic assistance a client receives is determined by clinic policies, the availability of professional staff and other community resources, the reason for referral, family cooperation and local professional practices, rather than by the actual need of the patient at the particular stage of his illness.

Partly because of the insufficiency of state and county outpatient systems, private psychiatrists have done their best to fill this gap, and the private practice of the specialty has expanded rapidly since World War II. As more community psychiatrists become available, this form of treatment is increasing in popularity, but because psychiatric treatment is time consuming, its cost is prohibitive to all but a very small group of relatively well-to-do patients. However, the commission's study reveals that psychiatrists working in clinics have recently started to function not only as therapists, but also as consultants, with the result that a significant part of treatment today is conducted, under psychiatric supervision, by clinical psychologists, psychiatric nurses, social workers, occupational therapists, or by any of a number of other psychiatrically trained people. The recommendation that more private-practice psychiatrists devote more of their working hours to community clinic services in both roles is important if enough adequately operated clinics are to be established.

Any reversal of the present-day trend toward keeping patients out of the hospital as long as possible, and discharging those admitted at an early date, seems unlikely. The fact that hospital costs continue to increase will give added impetus to treatment in the community. Thus we may expect the mental health clinic to occupy a key position in our range of psychiatric treatment facilities. Its clinical functions are already clear—to provide treatment for the seriously ill patient who can be helped without inpatient treatment, and for the expatient, so that he may be discharged earlier. Its educational function, while less clearly defined, (the Commission declares this to be "of incidental importance") is nonetheless emerging: to prove that treatment of psychiatric illness while the patient carries on his everyday activities is both practical and effective, and that even seriously ill patients can, for the most part, function successfully in the general community.

Because of the critical need for staff, the commission recommends that further measures be taken to train paramedical personnel; many are inadequately trained, but have the potential qualifications. Other recommendations include financial incentives and opportunities for professional development of additional staff people, leading to a career in clinic counseling.

EMERGENCY SERVICE

RECOMMENDATION: "Immediate professional attention should be provided in the community for persons at the onset of acutely disturbed, socially disruptive, and sometimes personally catastrophic behavior—that is, for persons suffering a major breakdown. The few pilot programs for immediate, or emergency, psychiatric care presently in existence should be expanded and extended as rapidly as personnel becomes available."

person who becomes acutely mentally ill is as much in need of emergency service as one suffering from a heart attack or from the results of an automobile accident. He needs professional attention without any delays—be they admission policies, a waiting list, his place of residence, ability to pay, or sheer lack of available professional help. The few pilot programs in existence indicate that emergency service units can be successfully operated in all kinds of settings—general hospitals, mental hospitals, mental health clinics, and perhaps elsewhere. The goal of such emergency service is secondary prevention: the Commission believes that early detection of mental illness, with immediate counseling and a referral to a psychiatric treatment facility if necessary will ultimately decrease the number of patients who have to be admitted to hospitals for long-term care. Quick and effective assistance can quiet an eruptive family situation—perhaps incidentally accomplishing some small degree of primary prevention!—and often indeed avoids a potential threat to society. To fulfill the recommendation of the commission, more liberal admission policies will be needed, and the cost of such programs must be subsidized by some comprehensive, voluntary prepayment plan, or by a publicly supported insurance program similar to Social Security.

GENERAL HOSPITAL PSYCHIATRIC UNITS

> RECOMMENDATION: "No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Every community general hospital of 100 or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region."

No community can consider its mental health facilities adequate unless they include a psychiatric unit in its general hospital. Some patients must have at least emergency or short-term hospitalization. General hospitals can offer high quality services and facilities with a minimum of delay—a highly important consideration when it is realized that the patient has the greatest chance of recovery during the earliest phase of his illness. An added advantage is that he is kept near his home, his family, and the family physician.

Despite the fact that less than one fifth of all general hospitals have a psychiatric unit or even psychiatric beds, these hospitals admit about 60 per cent of all patients hospitalized annually for psychiatric illness (This is nearly 18 per cent of the total patient-load in all mental hospitals.) This limited number of units has proved that it is feasible to provide the needed psychiatric inpatient facilities in a general hospital. As more psychiatrists become available, and are persuaded to move into small communities, the establishment of more psychiatric units becomes increasingly possible.

The usual policy of voluntary admission should be continued, and psychiatric patients whose condition permits should be allowed the same privileges as their fellow patients with physical or surgical illness. This is largely a question of staff education and indoctrination as to the needs and behavior of disturbed patients. All patients admitted to a general hospital acquire special rights; they voluntarily sought medical help, and take it for granted that in the community hospital, the nurses, the technicians, the doctors, and the army of other personnel are there to give them adequate care and treatment. The typical general hospital has a ratio of approximately two employees to each patient.

The admission policies and active treatment are geared to acute illness, mental or physical, with the expectation that the patient's stay will be brief. General hospitals are not equipped or staffed to render long-term intensive treatment or continued care to chronic patients, and their psychiatric units should not be expected to function except in conjunction with state hospitals or private psychiatric facilities geared to accept mentally ill patients who turn out to need longer-term treatment or care.

The main disadvantage of a general hospital psychiatric unit is its high cost—usually about $30 a day, not including the fee of the private psychiatrist. Nor is psychiatric illness adequately covered at present by Blue Cross or other policies. Low- and middle-income patients, therefore, cannot afford general-hospital treatment, nor can the hospital itself afford to finance a low-cost or no-cost program.

Moreover, the demands made on these units far exceed their facilities, and a bed may not always be available. The trend has been to add a ward, a unit, a wing, and even separate buildings in an endeavor to meet the increasing demands. Careful planning on a community-wide basis—taking into consideration the existence of a mental health clinic; other outpatient facilities; any private psychiatric hospitals, profit or non profit; a state hospital; and other community agencies—will be necessary if the commission's recommendation is to be effectively implemented. •

Librarian Joins A.P.A. Staff

THE A.P.A. Central Office staff recently welcomed its newest member, Jeremiah A. O'Mara, who will serve as Chief of the Library and Archival Services. Previously, Mr. O'Mara held the post of librarian at the Chicago Institute for Psychoanalysis for four and one-half years.

His first task is to establish a practical working library, primarily a reference collection to serve the information needs of the Council members, and of the Central Office staff in its day-to-day work. The new librarian is also preparing an index-abstract of the proceedings of the Council and of selected committees.

Long-term plans include the gathering of A.P.A. archives, manuscripts and first editions of classic works by U. S. and Canadian psychiatrists, correspondence, and other memorabilia to form a national historical library of American psychiatry. Mr. O'Mara hopes to obtain a copy of every publication issued by the Association since its founding in 1844. Contributions of books and documents of rare and historic interest are welcome.

The Private Hospital's Responsibility for Leadership*

By ROBERT S. GARBER, M.D.
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WE WHO ARE ENGAGED in private mental hospital work are proud of our pioneering efforts, our accomplishments, our steady progress toward increasingly effective treatment. We know that we render many distinct services to our communities, to our patients and their relatives, to psychiatry, and to medicine in general. We have unquestionably led the way toward realizing goals shared in common by both private and public hospitals.

For instance, long before tranquilizing drugs and other somatic treatments wrought their revolution in state mental hospitals, private hospitals were achieving that important triumvirate of goals: early hospitalization, concentrated treatment of acute illness, and a rapid return of the patient to his home. But there *has* been a revolution, and the entire climate of psychiatry is changing. It is time for us to thoughtfully define the private hospital's place in this changing medical climate and to assess our qualities for maintaining other leadership.

One thing is certain: we cannot be smug about our accomplishments. We cannot believe that we are so superior to state or general hospitals that we can settle back and rest on our laurels. I am convinced that, instead, we must continue to pave the way whenever we can, to share the enlightened path with our hospitals, and to show our willingness to learn from each other's experiences.

This conviction was born about four years ago. At that time a flurry of literature and a rush of visitors came to the United States from the United Kingdom. The visitors and their writings suggested that practices in American mental hospitals were out-of-style when compared with the more modern practices effective in British hospitals. As a public hospital administrator, I found these reactions to be not only disconcerting, but also unbelievable. I vociferously questioned their validity—and then was asked to join a small group of people who had been selected to visit the United Kingdom for firsthand observation of its hospitals.

The trip turned out to be an exceedingly profitable one. Although it did not fully substantiate our critics' impressions, it did show us that there *was* a different approach, and that it had been proving successful in the management of patients in a public hospital setting.

Soon after my return, I joined the private hospital ranks as an administrator, and was surprised to discover that practices we had observed in Great Britain—which I believed could never be accomplished in an American mental hospital—were actually being used in our own private clinic!

Such a revelation was distressing to one who believed he knew what was happening within administrative psychiatric circles in his own state. I was surprised to learn of the expeditious fashion in which patients at the Carrier Clinic were admitted, studied, classified, treated, and returned to their referring physicians after an average of 20.2 days of residence in the hospital. I was amazed to learn that an 89-bed private facility was admitting more patients in one year than a nearby 4,000-bed public hospital. I have never failed to astonish a listener with this story. I contend that it is the kind of story that must be told and retold to inform the public and our own associates of our successful private hospital practices.

Our National Association of Private Psychiatric Hospitals is one of the instruments we should use to foster increased awareness of what we are achieving. It is contingent upon the members to whittle program discussions into cohesive, comprehensive units for use as aids in implementing suggested improvements, and to facilitate the development of programs for research, training, and modern treatment methods.

We must promote a free exchange of ideas. The Carrier Clinic, for instance, has been engaged in a year's study of LSD, with very little knowledge that others were engaged in similar studies. We are dismayed to realize how little communication we have had with other private hospitals about this subject.

Why can't private hospitals get together in joint research projects? Why can't we discuss our findings back

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**Based on the keynote address presented at the 1961 Annual Meeting of the National Association of Private Psychiatric Hospitals.*

and forth? Why can't five, six, or ten hospitals engage in a similar research project so that results will not be based on just one hospital's 20, 40, or 50 cases, but perhaps on 1,000 patients from several hospitals?

In the process of exchanging information among ourselves and disseminating it to others, we must also refocus our attention on our obligations. *Our first obligation is to the patients who are referred to us.* Considering the size of our individual private hospitals, we treat a disproportionate number of patients, and generally reflect an abbreviated resident period of treatment per patient. The report of the November 1959 AMA Council on Mental Health meeting which appeared in the January 23, 1960, issue of *The Journal of the American Medical Association* stated: "Private psychiatric hospitals have 2 per cent of the psychiatric beds in the United States, yet receive some 40 per cent of all relatively acute and potentially recoverable first admissions."

"BUILT-IN" ADVANTAGES

Of course, we have certain "built-in" advantages over the state hospitals. We have fewer chronic disorders, such as cerebral arteriosclerosis and senile brain disease, and more psychoneurotics. Our patients are largely referred to us, many by psychiatrists, and we turn them back to these referring physicians at the end of their hospitalization. We have fewer aftercare problems than does the state hospital. Our professional staffs are usually better trained than their counterparts in state hospitals; this fact frequently leads to treatment of many patients who would not otherwise be treated.

For example, private hospitals with extensive loads of patients who are 70 years or older are compelled to individualize treatment and render personal attention. Because of this they find that many older patients can benefit from properly administered shock treatment and return to their homes in a revitalized frame of mind. In many state hospitals geriatric patients do not receive individual attention and study, are deprived of shock treatment, and vegetate on some back ward. In the Carrier Clinic, we treat geriatric patients who are not suitable for shock therapy with carefully selected medications. Most of them have responded to an amazing degree, and this success has encouraged the entire staff. This is the kind of problem we can handle so well in private hospitals because we have time to follow such cases more closely. But none of us must permit our "built-in" advantages to incline us toward oversimplifying solutions for mental hospital problems.

We have an obligation to the public. The alternative to hospitalization in a private psychiatric hospital is either in a general or in a public hospital. When we compare the private hospital with the state hospital, we have excellent evidence of private medicine outstripping state medicine because:

1. It does not involve any tax cost to the public.
2. Briefer residence periods in private hospitals make it possible for people to return to work sooner.
3. Since less time is lost from work, patients depend less on public assistance which, through employment insurance, must carry those who are in prolonged residence in a state hospital.

Let us not overlook the fact that the private hospital does not bear the stigma of "snake pit" which hangs heavily over the state mental hospital. We can do much in the community to counteract biased attitudes toward mental illness, thus encouraging people to seek treatment as early as possible. Each year we admit an increasing number of patients who have been stimulated to enter the hospital by former patients of ours. This is positive proof of an ever-diminishing fear of institutionalization, and is all the more reason for us to continue to improve our own standards and techniques for the benefit of our patients.

We have an obligation to our profession. We must prove that we are an integral part of medicine itself. It is vital that we interest ourselves in "the total hospital"—not just one particular area of the operating hospital, but in the entire hospital operation. We can accomplish this by stimulating research and training in many different categories: clinical approaches; treatment modalities, particularly those involving the newer drugs; administrative matters; the use of volunteers; work with families; work with employers and industry; and public relations.

Private hospitals must initiate more training programs for resident physicians, nonpsychiatric physicians, student nurses, practical nurses, ancillary aides, and volunteers. Such programs are extremely necessary to the operation of any active therapeutic hospital, and there is no more exhilarating experience than that of training students.

At the Carrier Clinic we have held seminars for general practitioners for the past several years, despite the fact that while very few psychiatrists oppose increased utilization of nonpsychiatric physicians, a lot of them do appear to drag their feet about it. Many in psychiatry seem to be waiting for the tomorrow that will bring the magic pill that cures schizophrenia, just as antibiotics cure infections. But psychiatry cannot afford to wait for that utopian day. We must learn to utilize better what we already have, and this utilization must undoubtedly include the nonpsychiatric physician.

The success of such seminars does not depend solely on whether or not GP's can be trained to recognize which mental illnesses they can treat, as opposed to which ones they should refer. Too often it is a question of whether or not they want to have anything to do with psychiatry in the first place. We can help to make this negative attitude less prevalent by approaching our goal in a positive manner.

These, then, are some of the things we have done, and some of the things we have yet to do. Leadership does not end with one accomplishment—or with a thousand; it continues as long as there is work to do. When one remembers that in the past many hospitals functioned as rivals to the others, and that solutions to problems, economies, and shortcuts were well guarded, we know that we have come a long way. Let's not forget that there is still far to go. •

Achieving Optimum Use of the Day Hospital*

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IT IS THE FATE of psychiatric innovations to lose their special significance quickly; to become bandwagons or status symbols, used without understanding or discrimination. To some extent this has been the fate of the tranquilizers and the therapeutic community. The day hospital is similarly threatened.

The purpose of this paper is to discuss how we can help the day hospital to escape such a fate. The mere fact that a day hospital has been established within a community is no guarantee of its optimum use, even in the presence of demonstrable need for such a facility. The general community and the medical and psychiatric professions must be well informed about its purpose, how it works, and how it compares with and relates to other treatment methods and facilities.

There are two main things we can do to help bring about optimum use of the day hospital. The first is to clarify our own thinking and be explicit about our concepts and practices. The second is to communicate these concepts adequately to others.

It is not sufficient to describe a day hospital simply as a place where patients may obtain full medical treatment yet return to their homes each night. A day hospital is not just an alternative to full inpatient or outpatient treatment. We can be more accurate and more explicit than this.

Psychiatric hospitalization provides more than protection for a patient, or a place for him to stay during treatment. Protection may be contraindicated, unnecessary, or no longer necessary for certain patients who, however, could benefit from the "something more" given by the day hospital—a therapeutic milieu available to them according to their needs. This "something more" has as much specific value as any other treatment modality.

The day hospital offers all of the therapeutic components of a psychiatric hospital treatment program, except those inherent in full-time living in the hospital under close nursing supervision. Many of these components depend upon the theoretical basis from which treatment is approached in any given institution. The main differences between inpatient and day-hospital programs lie in the time element; in the relative concentration of the day-hospital program within the activities therapy department; and its general orientation toward the "outside," for which the day-hospital patient is better prepared than the hospital inpatient.

Consideration of similarities and differences between hospital and day hospital raises questions about the relationship between the two, as well as between day-hospital and outpatient treatment. The latter needs an explicit answer because the two are often equated (this is part of the bandwagon fate).

CONFUSION WITH OUTPATIENT TREATMENT

One "day hospital" program, upon investigation, turned out to consist of only outpatient electroshock treatment. As an adjective, "outpatient" is applied to specific diagnostic or treatment procedures—x-ray examination, shock treatment, psychotherapy, vitamin injections, etc.—administered to a patient not residing in a hospital. These procedures may be conducted in the patient's home, his doctor's office, a clinic, or a hospital, without altering the fact that they are outpatient services. Therefore, strictly speaking, day-hospital treatment is outpatient treatment since the patients engaged in it are not residing in the hospital. But it is a specific kind of outpatient treatment, which neither excludes other kinds nor is interchangeable with them; it has its own special therapeutic value and content. It consists of the combined relationships and activities prescribed within the framework of the theory of treatment of the given institution, or of the attending psychiatrist.

The first day hospitals were developed in conjunction with psychiatric hospitals, and later, others were set up as separate facilities. Which is preferable? Obviously, a day hospital which is part of a hospital has certain advantages. In the first place, personnel, equipment, and space can be provided for it more economically than they can be duplicated at a different location. Quite a few day patients can be accommodated in an ongoing program of a well-staffed, well-equipped hospital of 50

**Based on a paper read at the 1961 Annual Meeting of the National Association of Private Psychiatric Hospitals.*

or 75 beds before additional staff or space are required. A separate day hospital requires duplication of staff and equipment even if it has only one patient.

Second, when a hospitalized patient improves and is ready to move into day-hospital treatment, or when a day-hospital patient relapses and needs temporary hospitalization, transfer from one service to the other can be accomplished without interruption of treatment if the facilities are together.

However important these two advantages are, there is another consideration which may outweigh them both: accessibility is limited when a day hospital is part of a psychiatric hospital located some distance from the population it serves. If one must choose between combined facilities at a distance, or separate facilities which permit a day hospital to be freely accessible, then one must sacrifice continuity of treatment to availability. Hospitalization at a distance from home has, I happen to believe, great advantages in some cases, but one of the reasons for day-hospital treatment is to keep the patient in his own community, and living at home at least part of the time. This is true whether "home" means the family home, a family-care home, or a residence maintained independently by the patient.

ANALYSIS OF PATIENTS

Among the kinds of patients who need hospital treatment on a full-time basis, regardless of duration, are those who: 1) are suicidal or actively dangerous to themselves and others; 2) are more indirectly destructive to themselves or others, and whose inadequate impulse control necessitates treatment under close supervision; 3) need removal from pathogenic family relationships or other environmental stresses; 4) are so immobilized by their psychopathology that they cannot participate in treatment on an outpatient basis.

Patients who need hospital treatment on something less than a full-time basis are those who: 1) once needed full-time hospital treatment and no longer do, but still need a more extensive therapeutic program than is available on an outpatient basis, or who need a more gradual transition between hospital and the community; 2) have never needed hospitalization, but whose psychopathology is such that they require a wider range of therapeutic activities and relationships, or opportunities to develop new and better outlets for their impulses, or supervised opportunities for socialization, or partial relief from environmental and family stresses.

In the paragraph above, the time element—"something less than a full-time basis"—was purposely left vague. This allows for the varying needs of patients and the varying policies of day hospitals. Facilities in some day hospitals are available from 9 a.m. until 9 or 10 p.m. every day of the week; others are open only part of each day, or part of each week. Whatever the limitations of time may be, there should be sufficient flexibility to allow for variations in patients' needs.

Day hospitals may also be used to advantage in the following peripheral ways: 1) as an adjunct to office diagnostic evaluations, when observation of the patient in the day-hospital program may be of help in formulating diagnosis or treatment recommendations; 2) as a neutral setting in which patient and relative—if there has been a long separation between the two—may work and play together, and get reacquainted before the patient is discharged.

These, then, are some of the practices and purposes we must consider and clarify if we are to make better use of day hospitals. The next step is to communicate our ideas to others: to hospital staffs; to the general public, who must be given some knowledge, even if limited, about the day hospital in order to understand and cooperate with recommendations for its use; and to those who refer patients to us (usually psychiatrists).

ORIENTING THE PSYCHIATRIST

With particular reference to psychiatrists, communication is not as simple as it sounds. There is relatively little difficulty in educating the psychiatrist who is engaged in full-time hospital work. His interest in and willingness to learn about all of the ramifications of treatment, including that offered by the day hospital, are attested to by his choice of hospital work. In addition, he is on the spot, available to be given whatever training he needs.

On the other hand, there is the private practitioner, who is either a potential referrer of patients, or a member of the open staff of a hospital. He may devote the greatest part of his time, attention, and interest to his office practice, and consider the hospital a convenient place to keep a difficult patient to whom he gives a little therapy each day or so. In such a situation, there is the dual problem of the doctor's unavailability, and, even if he does happen to be available, of engaging his attention and interest in acquiring knowledge he may not know he lacks.

This ivory-tower type of practitioner, while far from imaginary and nonexistent, is happily diminishing in number. But with the advent of more psychiatric facilities in general hospitals and urban psychiatric hospitals, it is our responsibility to familiarize the private-practice psychiatrist with the programs of these facilities and of the day hospital.

There is a lot of work to be done to keep the day hospital from becoming an empty concept—a term used because it is fashionable rather than because it is accurate and descriptive. We must develop our programs on sound theoretical bases, staff them well, and provide good inservice education to insure constant maintenance of high standards of treatment. We must make our day hospitals as geographically available as possible to potential patients, and be flexible as to the hours they will operate, depending upon the patients' needs. We must develop clear ideas about the types of patients for whom day hospital treatment is indicated, and about how the day hospital relates to other facilities within the hospital and to the total community. We must clarify our relationships with our colleagues, and do what we can to help them and ourselves to use the day hospital to the best advantage of the patients. Finally, we must continue to share with each other what we learn about the best ways to accomplish all of this. •

DISASTER PLANNING

FIRE AND TORNADO

By ROBERT N. SIMMONS

Caro State Hospital for Epileptics
Caro, Michigan

PUBLIC APATHY toward disaster planning is widespread in the United States, especially in areas which have never directly experienced a disaster. At Caro State Hospital, we shared this complacent attitude until aroused by a vigorous public-awareness program sponsored jointly by the Michigan State Fire Marshall and the Michigan Office of Civil Defense Mobilization. Our recent decision to develop a disaster plan and a related training program will enable the hospital to save lives and reduce property loss in case of a disaster emergency.

Caro State Hospital has a patient-employee population of 2,500. Its 1,400 acres encompass 18 cottages and two infirmaries for housing patients, a powerhouse, store, laundry, bakery, large central kitchen, schoolhouse and other facilities which make it virtually self-sustaining. Developing its disaster plan involved most of the problems common to large hospitals, colleges and universities, and even communities of a comparable size. Therefore, our experiences in setting up the plan should be of interest and value to other institutions.

METHODS OF APPROACH

Preparatory to the actual development of a disaster plan, the hospital administrator should use an enthusiastic, firm approach in motivating department heads and first line supervisors. The first person to stimulate is the one who is to author the plan. The administrator should consider the potential author's abilities to collect and correlate information, and determine whether or not he is genuinely interested in the project. He should also solicit the cooperation of the director of nurses and the chief engineer; their departments will ultimately play an important role in employee motivation.

After having been selected to author the Caro plan, I searched for written material on the subject. Numerous articles, general in nature, helped me to determine

methods of approach, although no material was available which outlined step-by-step procedures. The state fire marshall's office furnished particularly valuable information.

We used the U. S. Army's system of decentralized control in developing our plan and our procedures manual. Basically, this system of unit operation calls for a series of definite plans in which each unit operates independently of related units, but, at the same time, interlocks its functions with the over-all mission of the central headquarters. For instance, if a disaster occurs, the hospital's engineering department will send all available vehicles to the disaster area, where they will be used for evacuation. Simultaneously, the nursing department will dispatch medical personnel to provide emergency treatment. Both departments will be authorized to proceed by notification from the switchboard operator that a disaster exists. In this way, department heads can implement action immediately without sanction from the administrator, and will not have to coordinate with each other before proceeding.

Imagine the delay in action and the communication problems that would arise if the administrator had to organize his key personnel before the disaster procedure could be started. Under a centralized system of control many decisions which could be made by department heads would be delayed by unnecessary contact with the administrator. Therefore, the system of prior planning at the department level offers these advantages:

1) The administrator is relieved from time-wasting coordination with department heads.

2) Department heads and key personnel are directly responsible for implementing their plans.

3) The number of management decisions is reduced.

4) Management knows what is being done by each department.

5) Employees take orders from the person who supervises them under ordinary conditions.

The last point requires further emphasis, primarily because during the first few hours of a disaster conditions are so tense that many persons cannot function adequately without close supervision. Most activity occurs during this "shock period," and it is reasonable to assume that a confused person would accept orders more readily from his regular supervisor than from someone with whom he has had limited contact.

MANUAL OF PROCEDURE

The most important disaster operation is immediate action to save lives and alleviate the possibility of further injury. Thus, employees must know what is expected of them without having to refer to a manual for instructions. A detailed manual which outlines numerous specific duties for an employee may be a literary accomplishment, but it is of very little value if it is not practical. No more than four or five duties should be assigned to each employee because people under stress cannot be expected to remember a long list of responsibilities.

The over-all Caro plan includes procedures for dealing with fires and tornadoes. It outlines individual responsibilities under both conditions. There are three basic areas of responsibility:

The General Administrative Plan establishes internal and external control policies. Internal control governs disaster procedures within the institution. External control involves facilities of adjacent towns and cities. For instance, the chief engineer, under internal control provisions, is responsible for insuring that fire prevention rules are observed, procuring and maintaining disaster equipment, and training personnel to use the equipment. Under external control provisions, he coordinates assistance offered by supporting disaster units and takes charge of transportation.

Under *The Department Plan*, each department is assigned a specific mission and instructed to act immediately without consideration for the mission of other departments. The department head is given authority to accomplish his mission so long as his decisions do not conflict with provisions of the General Administrative Plan. In other words, the plan does not tell him how to deploy his personnel, but rather that he must perform his duties with whatever manpower is available to him at the time of the disaster. For instance, the nursing department is directed to:

1) Send registered nurses and attendants to the disaster scene.

2) Assign a registered nurse and attendants to hospital receiving to assist the receiving physician.

3) Insure that a nurse is located at each casualty collecting point.

4) Delegate one nurse and attendants to assume charge of the minor treatment area at the schoolhouse.

5) Have the surgical nurses report to surgery.

The director of nurses is responsible for accomplishing these duties and devising methods of performing them. The administrator is not concerned with the selection or deployment of nursing personnel; his only concern is that the nursing department's mission is being carried out according to plan.

The Building Plan supplements the policies of the administrative plan and the operational department plans by outlining procedures for each building. It provides specific instructions so that employees within a building will know what to do during a fire or upon notification of a tornado forecast or warning. The fire plan designates routes of horizontal and vertical evacuation to safe areas, and includes instructions for extinguishing fires and taking head counts if the building is completely evacuated.

The building tornado plan is divided into two sections; one for action to be taken following a "tornado forecast," and the other to be followed after a "tornado warning." Forecast plans require preparation of the northwest corner of the basement (or hallways, in buildings without a basement) for the reception of patients; warning plans emphasize moving patients to safe areas.

COORDINATION WITH CIVIL AGENCIES

An institution or hospital, regardless of its size, cannot cope with disaster problems alone; it must rely on available support from adjacent cities, counties, and state

civil defense organizations. Since these agencies usually are more capable than institutions of furnishing supplies, medicines, transportation, communications, and manpower, the institution disaster plan should supplement the plans of these higher level agencies.

THE TRAINING PROGRAM

Concurrent with the development of the disaster plan, we devised a training program to familiarize employees with the plan and to train them in emergency medical treatment, evacuation, and fire fighting. The length and intensity of the program depends on how much training the employees have had already, and on the costs involved in relieving personnel from their jobs to attend classes.

The Caro plan stipulates an 11-hour program broken down into two-hour training periods in fire prevention, disaster procedures, and emergency medical treatment; and two and one-half hour periods for evacuation and receiving, and fire-fighting techniques. The instructors, naturally, should be skilled in their respective fields.

Scheduling employees involves numerous considerations, especially in institutions where operation is around-the-clock. At Caro, instructors teach classes during the evening hours which means that, during this time, there is minimum coverage in the cottages. However, this arrangement greatly decreases the amount of overtime required for evening employees to take instruction during daylight hours.

Shortly after our manual was published, we began training staff and supervisory personnel to comply with the fire prevention check-list. This is a list of rules obtained from the state fire marshall plus additional hospital rules. Most of the state regulations pertain to building construction, proper use of electrical appliances, and maintenance of fire-fighting equipment. Institutional rules concern housekeeping duties directly related to fire and accident prevention. Specific rules include an inspection of all fire extinguishers, hoses, and hydrants; placing extinguishers in areas where fires are most likely to begin; identifying fire alarms and equipment with red paint; and removing fire hazards such as accumulations of boxes and paper.

After the first phase of the training was successful, the nursing department began instruction in emergency medical treatment. At this writing approximately 400 employees have attended disaster meetings which will continue until each employee has satisfactorily completed 11 hours of instruction.

In the final analysis, no plan guarantees a satisfactory solution to all possible disaster problems. We cannot predict the type or extent of a disaster, or assume that employees will function rationally during one. Furthermore, a plan providing a course of action for any possible contingency would be much too complex to be practical. The important consideration is that, with a plan, the possibility of survival is greater than it would be without any organized effort at all

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SPECIFICITY OF MILIEU THERAPY

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MANY PSYCHIATRISTS BELIEVE that a patient's milieu must be as specific to his needs as his treatment. The authors would like to illustrate this theory by reporting their experiences in helping to create a particular type of milieu for psychiatric patients in a general hospital.

In August 1956, the 280-bed Mercy-Douglass Hospital in Philadelphia opened an 85-bed psychiatric unit. This unit, as part of the University of Pennsylvania's department of psychiatry, has important training and research functions, in addition to its service functions. Consequently, its atmosphere is considerably influenced by the large turnover among staff members who come to the unit primarily for training.

Since Mercy-Douglass is a general hospital, psychiatric inpatient facilities were not included in its original construction plans. The two floors now occupied by the psychiatric department were designed to accommodate general medical patients in private and semiprivate rooms. When the present unit was established, no changes were made in the rooms or their furnishings, except to install retention screens.

Each room contains cabinets, closets, mirrors, sinks, etc., freely available to the patients. One floor is "closed" for disturbed patients; the other is "open" for convalescing patients. Both floors consist of two wings separated by a large sitting room or lobby. One wing contains rooms for the men; the other houses the women. However, doors to the wings are left open so that men and women can mix freely on both floors and have meals together in the dining room located in the women's wing.

Patients are admitted to the unit after brief screening at the Philadelphia General Hospital Psychiatric Reception Center. The center's staff examines all applicants for local public psychiatric hospitalization, and refers them to one of four facilities. During the unit's first year of operation, our own staff members did no screening, but accepted all types of acutely ill patients. Subsequent experience prompted us to limit certain categories of patients. Empirical observation revealed that our type of milieu is not particularly helpful in treating personality disorders and the more integrated psychoneurotic categories, but is of definite benefit in treating functional psychoses where isolation and regression are often seen to a marked degree. As far as patients with "acting-out" tendencies are concerned, the milieu is actually detrimental.

To give an example of our annual admissions—in 1958 we admitted 250 patients: 137 with a diagnosis of schizophrenia, 30 with affective reactions, 19 with acute or chronic brain syndromes, 48 with neurotic reactions or personality disorders, and 16 with unclassified disorders.

The majority of our patients come from the lower and lower-middle class urban population. Most of them have been ill for relatively short periods of time before admission, and many experience their first hospitalization when they enter the unit. Although the unit is supposed to provide only short periods of inpatient treatment, no absolute time limit has been set. The average duration of stay is 85 days, but some patients remain for as long as two years, and others transfer within a month to other hospitals that provide a more prolonged treatment program.

In order to combat isolation and regression, the unit's milieu is designed to support the relatively intact portions of the patient's ego. Patients are encouraged and expected to assume considerable responsibility for themselves and for other members of their community. For example, patient-government groups make decisions about the frequency and duration of visiting hours, the availability of telephones, and the planning of recreational activities.

Distinctions between inpatients and outpatients, patients and staff, mentally ill and mentally well, have been purposely reduced to combat feelings of isolation. For awhile, removal of these distinctions created some confusion among patients and personnel as to their respective roles. However, as both groups came to depend less upon rigidly defined roles as part of their defensive armamentaria, they substituted defenses that were less therapeutically inhibiting. Physicians began to accept the attitude that their ministrations to the patients were not the sum total of psychiatric treatment; nurses and attendants worked with patients as equals on problems of ward administration and housekeeping; and the patients began to feel that they had something positive to contribute to their own therapy and rehabilitation.

We also stress direct and quick communication,

rather than "channels"; administrative, physicians', and nurses' offices are placed alongside patients' rooms and recreation areas. Patients may call a physician for a nurse just as easily as a physician calls a nurse for a patient; an attendant may request a conference as readily as the chief of service. Patients and staff participate in many joint conferences and recreational activities.

Another effective technique in reducing isolation and regression is that of housing men and women patients on the same floor, so that they may share dining and recreation areas and mingle together in many types of group interaction. Whenever possible, patients share activities with members of the nonpsychiatric community, such as being assigned to nonpsychiatric areas of the hospital, working in the community while continuing to live in the hospital, attending recreational activities made available through the city department of recreation, and making frequent visits to their homes.

PRIVILEGES ARE RESPONSIBILITIES

We attempt to scale the scope of these activities and interactions to the individual patient's ability to assume such responsibilities. The patient is told that each extension of activity is a responsibility rather than a privilege; he is given open-ward or home-visit "privileges." We see these as important aids to recovery, not as rewards for getting well.

The relative permissiveness and fluidity of our nonauthoritarian milieu has both advantages and disadvantages, depending in large part on the types of psychopathology reacting within. Since patients are partially responsible for their own social structure, their identification with a group is facilitated, and indeed often mirrors their own inner needs and problems.

Even though our milieu is based on permissiveness, the patients automatically and inevitably set up authority figures. Transference phenomena develop spontaneously; an attempt is made to recognize their emergence, but not to control their direction. One result of this situation is that sibling rivalry problems are expressed more often than parent-child relationships. Patients frequently developed transference feelings toward other patients.

An important factor in structuring any type of milieu therapy is that it must represent social realities, but must also be flexible enough to be adapted to the changing capacities of patients. This, of necessity, imposes a heavy obligation on the staff to maintain close individual contact with patients in a setting which emphasizes group and social identifications rather than individual transference.

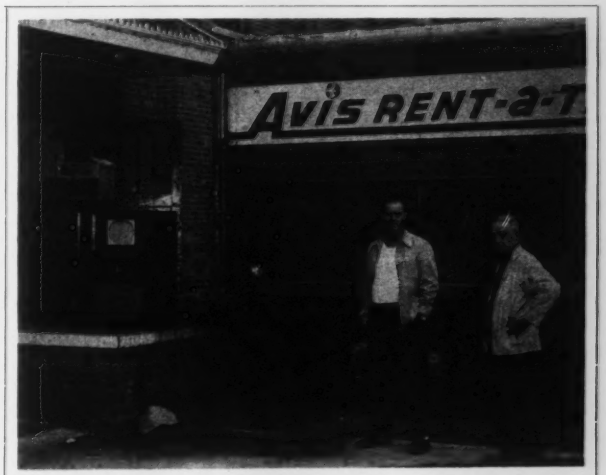
We expect the staff to be more flexible than the patients in meeting their own psychological needs, but our experience indicates that our type of therapeutic setting often disturbs physicians, particularly younger ones who are just entering psychiatric training. To some extent, this reaction depends upon the degree to which their self-esteem is based on traditional roles and the status enjoyed by physicians in the usual medical setting. Some of the younger graduate nurses face the same problem.

Other members of the psychological community—attendants, recreation therapists, occupational therapists, social workers, and psychologists—are able to realize their full potentialities in such a milieu. For example, one of the social workers conducted a meeting of relatives to discuss how they could help in the rehabilitation of patients. Another social worker conducted a discussion with convalescing patients to explore problems they were likely to face when they started to look for jobs. The milieu cannot operate effectively unless it satisfactorily meets the needs of both patients and staff. •

Mental Hospitals to Publish 12 Issues

Starting with the new subscription year, 1961-1962, subscribers to the A.P.A. Mental Hospital Services will receive 12 issues of MENTAL HOSPITALS annually instead of 10. The two additional issues will be published in July and August.

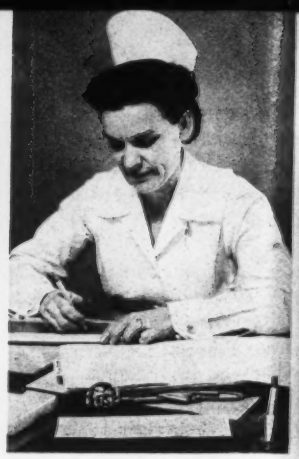
By increasing the number of issues the Editor hopes to publish good material at an earlier date, and also to include more information of topical interest, especially news emanating from Washington where not only the Federal Government, but so many professional organizations associated with mental health operate. We hope that our readers themselves will help keep the magazine topical by sending news about state developments, such as new construction projects, special research grants, use of matching funds, and new training programs.



DELIVERING THE COMMUNITY'S GIFTS

When Mr. Joseph Paquette of Saginaw, Michigan, read a news item about the Traverse City State Hospital's need for certain articles, he launched and coordinated a local drive to collect donations. The community's response was immediate and gratifying; even the use of the truck which transported its tokens of good will was granted free-of-charge. Above, Mr. Paquette (right) and Mr. Chester Rousseau pause for a picture after delivering the first of two van-loads of clothing, cosmetics, jewelry, radios, television sets, pianos, and many other items to the hospital's patients.

Research psychologist (left) plans placement of data on the cards. Admissions clerk (right) records patient-information.



Coding is done by the registrar; the ward nurse records information about the patient's treatment, supervision, and behavior.

AUTOMATIC DATA PROCESSING OR

WHAT DO YOU KNOW about the patients in psychiatric hospitals today? Do you know where they were born, how far they went in school, their occupations, work histories, leisure time interests, physical disabilities, marital status, or religion? What do you know about the types, frequency, and severity of behavioral problems among patients?

The Medical Audit Plan for Psychiatric Hospitals, supported jointly by the Veterans Administration and the National Institute of Mental Health, and sponsored by the Johns Hopkins University, recently completed a project to enable a hospital to determine rapidly the characteristics of its patient-population. This article outlines the general principles as well as some of the advantages of applying automatic data processing to record keeping. The discussion is based on experience gained in planning such a system for the VA Hospital at Perry Point, Maryland.

The Perry Point Patient Record System differs in purpose from standard patient-record keeping methods as typified by the clinical folder. Clinical records are patient-oriented—case histories, progress notes, and doctors' orders are designed to facilitate understanding of a particular patient as an individual. The Perry Point system includes only patient-information which is of current concern to the hospital. It is therefore *characteristic-oriented* rather than patient-oriented, and is compatible with high-speed data processing equipment which can perform the following functions:

Locating: A patient or group of patients possessing a particular characteristic or group of characteristics can be located. This helps to answer such requests as, "Do we have a bass player?" "Locate patients who are currently receiving no specific treatment." "Find all patients who have been hospitalized ten years or longer." "Locate all patients who are members of the Catholic Church." "Find all patients who were born in Europe." "Locate all patients who are convulsive."

Counting: Rapid counts of patients, totally or by breakdowns on sub-characteristics, make it possible to answer most "how many" questions. For instance, "How many patients are age 65 or over?" "How many patients eloped last month?" "How many patients have no known relatives?" "How many patients have not been out of the hospital on leave during the past two years?"

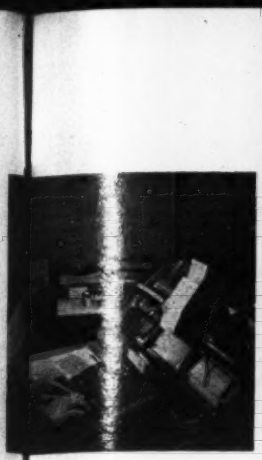
Listing: After the desired groups of patients have been located, lists and reports can be prepared. Ward lists, special lists of patients, and tabular reports can be printed automatically.

AUTOMATIC DATA PROCESSING EQUIPMENT

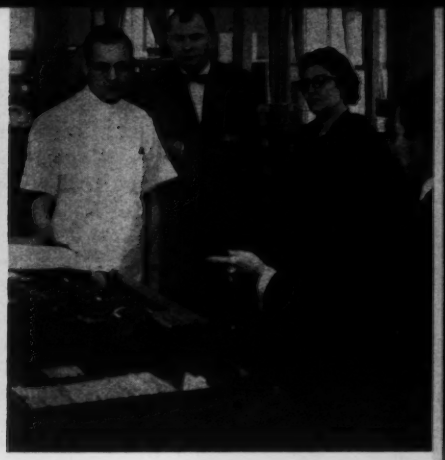
IBM equipment is used at Perry Point, but there are other machines that are equally serviceable. This equipment is based on the unit-record in which a punched card, marked in columns, refers to a single patient. Each card contains as many as 80 items of information about the patient. These items are reduced to numerical form. In practice, many items of information require more than one column. For example, state of residence requires two columns in which Alabama is reduced to a numerical code of 01, Arizona is 02, and so on to Wyoming, which is 50. The codes for residence and birthplace require ten columns, but make it possible to locate every major country in the world plus a number of territories; and for the United States, Canada, and Mexico, every county, town, and population grouping of over 2,500. Although one such item may take up several columns, the number of cards which can be prepared for a single patient is unlimited. Thus, a card might be reserved for admissions, one for examinations, and another for nursing problems.

ADVANTAGES OF DATA PROCESSING

Speed and Accuracy: Record systems on punched cards far surpass in speed and accuracy any other method of obtaining information. The automatic data processing equipment at Perry Point can sort the entire patient-population on one column of information in less than three minutes, at the rate of 650 cards per minute, and even faster equipment is available.



Patient-information is transferred to cards on the keypunch (left). Then the cards are selected and arranged on the sorter.



Wired-in programming (left) sets up desired reports which tabulating machine (right) produces for the hospital staff's use.

...PATIENTS' RECORDS

By SHIRLEY KLETT, Ph.D.,
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Accuracy of patient-records is improved because, in the long run, a report prepared mechanically is more accurate than one compiled by hand, provided the information put into the basic record system is as accurate as that from which the hand compilation is done.

In addition, personnel are freed from hundreds of man hours spent in hand compilations. More time devoted to the creative and rewarding aspects of their jobs should lead to a commensurate improvement in the quality of the basic records, and, therefore, in their accuracy.

The system also makes it easier to detect errors. Since the patient-population can be put into any desired order according to a particular characteristic, it is a simple matter to locate obvious types of errors which so frequently escape notice in the hand-kept system, e.g., a hospital number assigned to two different patients, the admission date which is "out of order" when compared to the hospital number, or the birthdate which is not logical when compared to the admission date.

Scope and Flexibility: Routine reports can be completed within hours after the specific information is requested. Since reports are in a state of flux, statistical enumerations required this year may not be required the next. What is gained is the flexibility to reorder the patient-population according to changing needs with an ease impossible with hand-kept records. This is particularly true of the host of records maintained on a cumulative day-to-day basis. In addition to supplying routine reports, it is possible to supply answers to a multitude of questions which are asked almost daily in our hospitals—questions for which no answers were previously available except through special studies. For instance, if a community church group wants to give a Christmas party for patients who are members of its church, the hospital record department need not be thrown into utter confusion. When church membership is coded on punched cards, such a request can be met in as little time as ten minutes.

A unique characteristic not found in other patient-record keeping systems is the ability to reconstruct the exact patient-population at any point of time in the past, dating from the time the record system was installed. In the light of changing conditions in psychiatric hospitals, this feature can be extremely useful. It permits the preparation of figures for comparison with present reports, and highlights the need to incorporate information into the system with possible future needs in mind.

Far too much time is wasted in most hospitals by different staff members comparing essentially the same information. Time must still be spent in recording information for the punched-card system, and in making routine changes, but once the information is incorporated, reports can be compiled with a minimum of effort for rapid distribution to all points where it is needed. Since information from all appropriate services is pooled in one system, every hospital department stands to benefit from the increased amount of information available.

Quality of Patient Care: The possibilities for improving care by the use of readily accessible patient-information are limited only by the imagination of the staff.

1. Staff involved directly in patient-care usually spend a great deal of time in paper work, much of which can be eliminated to allow more time for actual work with patients. This is particularly true of the nursing service. Nursing personnel frequently are called upon to search their wards for patients possessing certain characteristics—perhaps to fill a fourth for bridge.

2. This patient-record system helps to eliminate the "forgotten patient," who is a frequent problem in hospitals which do not use ward assignments. If information regarding the staff is also punched, it is a matter of routine checking to make sure that a staff member is assigned to each patient. The forgotten patient may be one with special physical problems which are not receiving attention, one who has not had a physical examination recently, one who is receiving no specific treatment, etc. Patients whose leisure time interests are not provided for by the recreation department also come under

the "forgotten" category. Information about patients' occupations, educational backgrounds, and incomes enables the rehabilitation services to locate those who need special attention in these areas.

3. Routine analyses of patient-load per staff member, per ward, or per special service can be a simple matter. Such analyses frequently reveal problem areas before they become obvious. Sometimes a simple redistribution of patients, staff, or operating funds can be useful in increasing efficiency. Such studies are also helpful in planning new programs, and the analyses upon which the programs are planned would be valuable in seeking increased operating funds for such purposes.

4. Finally, the possibility of bringing unsuspected problems to light seems good. For example, an unusual distribution of admission diagnoses at Perry Point led to a study of the admitting examinations which reduced the number of "catch-all" diagnoses.

PLANNING AND INSTALLATION

Automatic data processing serves many useful purposes in a psychiatric hospital besides record keeping. Most of the fiscal operations can be reduced to machine work, including the payroll and the printing of checks. Similarly, supply inventories and personnel records can be maintained on punched cards. Whether or not a hospital already has data processing equipment, a careful study of the long-range demands is necessary in order to achieve the ultimate combination of machines suited to a hospital's needs. Since the Perry Point equipment is used by several hospital departments for varying purposes, administration of the processing center is handled directly by the hospital's manager. Assistance in selecting equipment and personnel and in planning operations can be obtained from consultants available from most processing-equipment manufacturers.

The following suggestions, based upon Perry Point experience, are offered for actual planning:

1. The first goal in setting up a data processing system should be educational in nature. Encourage staff to learn as much as possible about a comprehensive characteristic-oriented record system, and about automatic data processing in general. Since the intent is to supplement rather than to replace basic clinical records and to relieve personnel of routines rather than to replace them, the system must be justified on the basis of its added advantages. It is also important for staff to learn that the results of automatic data processing methods are only as good as the information upon which they are based. Thoroughness of initial planning is essential, and without informed staff members who can contribute to the planning from the very beginning, the outcome is likely to prove disappointing.

2. It is better to plan the system as the hospital would ultimately like to use it, even though an actual start is made with only portions of the system. This means leaving spaces (or whole cards) blank for the later inclusion of data from other sources.

3. When obtaining information from one source (such as the admissions forms) include every item which can have any possible usefulness in the future. Similarly, it is better to code the items too finely than to do the reverse. Both of these suggestions apply because items can be dropped or regrouped by machine in order to add others. Otherwise, finer recording requires going back to the original source, resulting in a waste of man hours.

4. Items to be included can be determined by requesting each department chief to prepare a list of all information which would be of interest to that service. This type of collection, if department heads have a reasonably clear idea of its purpose, will include most factual items of future usefulness. Efforts should be made to project thinking as far into the future as possible, because some types of ultimately needed information may otherwise be omitted. In addition, information primarily useful in research is less likely to be included because staff members do not have time to think about research. Since this system is ideally suited to research purposes, thought should be given to including research-oriented items. For example, it is not difficult to include birthplace of each patient's parent. Such an item seldom serves a practical operating purpose, but can be valuable in research studies. If the hospital has very little active research work going on among its staff members, advice about useful items can be obtained from mental health research specialists at nearby universities.

The major work involved in actual installation is that of coding items for the backlog of patients in the hospital on the day the system goes into effect. Maintaining the system on a day-to-day basis, once it is installed, is a relatively simple matter. Since a lapse will occur between the time coding is begun and the system is ready for operation, a "locator card" should be punched immediately. This can be done in a few days, and requires little, if any, coding time. A locator card would contain basic information about each patient—his name, hospital number, date of admission, number of times admitted, ward number, birthdate, and date of loss from the hospital. Sex, race, and the type of loss from the hospital are minor coding problems and could be included with ease. Thus, while the coding task (or even the planning) proceeds, practice can be gained in methods of keeping records current and of preparing lists, reports, and computations. Furthermore, the locator card can be used to perform demonstrations for hospital staff members. When the entire system is complete, the locator card can serve as the source of basic information to correlate with more detailed information on other cards.

Although these automatic data processing methods can be applied successfully to the problems of patient-records in psychiatric hospitals, the authors must emphasize that the Perry Point system is only a supplement to the basic clinical records, not a substitute for them. It is oriented to questions about the characteristics of patient groups rather than to the individual patient. However, it provides speed, accuracy, scope, and flexibility not found in any other type of patient-record system. The numerous benefits derived from such a system, when it has been planned properly, make for increased efficiency and improved quality of patient care. •

A copy of the original Perry Point VA Hospital Coding Manual may be obtained from the authors.

The Psychiatric Social Worker as Leader of a Group

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It was in 1947 that the first psychiatric social worker in Massachusetts took over leadership of a therapy group. This was at Boston State Hospital, but the idea soon spread to other psychiatric hospitals and agencies in the state, both public and private. Two years later there was so much interest in this new field that the Massachusetts Association for Mental Health, in cooperation with Boston University School of Social Work, sponsored seminars in beginning and advanced group psychology, conducted by psychiatrists. By 1955, over 125 social workers in the area had received such training.

Six of those who had had two or more years of the training, plus experience in leading groups, made a pilot study of the Massachusetts experience for a local branch of the American Association of Psychiatric Social Workers. This led naturally to interest in what was going on in the rest of the country and to a nationwide survey by the same six as a subcommittee of the Committee on Practice of the Psychiatric Social Work Section of the National Association of Social Workers. The following is a summary of the subcommittee's report:*

The entire membership of the Psychiatric Section of N.A.S.W. was polled by questionnaire to find out how many members were leading groups; the nature of their training for group work; types of groups they conducted; their treatment methods and goals. The committee defined as pertinent for its study only groups with a therapeutic focus, where the method was discussion, role-playing, play therapy, or a combination of these; and where the purpose was modification of attitudes, development of self-awareness, or better functioning in interpersonal relationships. Also surveyed were some personnel groups which had the added aim of teaching group dynamics. To be included in the survey, groups must have met at least six times.

Forty-eight per cent (1,468) of all the members responded. Of these, 547 reported they were leading groups, but further data revealed that only 350 of them were leading 456 groups which met the committee's definition. Most of these 350 group leaders (247) were working in adult psychiatric settings; 71 were in children's psychiatric agencies; and 32 in other organizations, such as family and children's agencies.

The survey revealed a very wide variety on all points of leadership and group composition. All leaders had Masters' degrees; over 80 per cent had more than a year's casework experience, and fully half had at least four years. But almost one quarter had no special training in group dynamics or experience as recorder-observer. Even of the 204 who reported some such training, 33 had taken seminars or courses lasting less than one month. At the other end of the scale were 35 who had had more than two years specialized training.

Although 87 per cent of the leaders reported they had some form of supervision, usually by psychiatrists, they expressed a common plea for more inservice training, more contact with experienced group therapists, more published material in social work journals, more research, and the development of a common vocabulary.

Only 60 of the 456 groups employed role-playing, and even in these, the discussion technique was often used. Twenty-two per cent (102) of the groups had been in existence for less than six months, meeting 10 to 25 times within that period. Eighteen per cent (82) had been in existence for two years and were still active.

In the majority of the groups reported, screening was common practice and participants had been individually selected. Members were chosen on the basis of individual needs, willingness, and indications that they could participate to some degree. Usually there was

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also some common denominator of diagnosis or problem. For instance, stressing diagnosis, one mental hospital group was composed of "ambulatory schizophrenics whose egos are strong enough to withstand the group pressure and who can benefit from group support." Another group was composed of sex offenders.

Less specifically, patients might be brought together on the basis of chronicity or acute onset of their illness. Mixed diagnoses were not unusual if a group was seen as having a common problem. Thus one group was described as being made up of "ambulatory schizophrenics in good remission; patients with deep-seated dependent reactions; patients with psychoneurotic disorders or other personality disorders." Although diagnosed differently, all were struggling with their dependency, feelings of inadequacy or impotence, and failure to work up to their potential.

A family agency formed a group of adolescent Negro girls, wards of the Welfare Department, who had "exhibited anti-social behavior": a general hospital formed a group for youthful epileptics who needed to accept their illness and better their interpersonal relationships.

In groups of relatives, the common problem might be their relationship to a sick family member, whether the latter had brain injury, cerebral palsy, or psychosis. These groups include parents, wives, or husbands of patients. At least one psychiatric hospital revealed added reasons for seeing certain mothers of schizophrenic patients: they had not worked out in individual casework treatment, they were "hypercritical" of the hospital, and they interfered with their children's treatment.

According to the answers obtained from this survey, there remains one other method of selection of relatives' groups: the client or patient asks for it. At least two examples of this were given: one of male alcoholics who wanted their wives to be in group therapy, and one of 15 women mental patients who asked that a group be formed of their husbands, a father, "and in one case a sister."

Outpatient and community agencies tended to exclude from their groups grossly psychotic, disturbed, or even "infantile" people as disrupting elements. In the psychiatric hospitals, homogeneity of social, cultural, and educational levels appeared to be largely disregarded.

This was less often the case in outpatient departments or clinics. For example:

> "Family, social, and cultural problems are paramount and observable to the staff in this patient-group. All are of Central European extraction, come from intact family groups, and indicate some pride in parental roles and aspirations to more adequately meet adult family responsibilities. This is a peer group with stress upon building morale through group identification and upon arousal of healthy group emotions. It was planned as an aid in patient-use of individual treatment, and as a supplement to or preferable substitute for individual treatment."

Besides the accent on similarity of diagnosis, problem, or socioeconomic background, respondents to the questionnaire reported another selection criterion, which might be labeled "difference." More commonly it was spoken of as "balance." In essence, it meant including in a group individuals who behaved differently. The purpose was to promote interaction and self-awareness among members. Some quotes from the questionnaire answers:

From a mental hospital:

> "Group of female patients from a semi-open, convalescent cottage—both long- and short-term hospitalization. We try to maintain a balance between the more verbal, aggressive, hostile patients and the more passive, dependent, withdrawn, verbally unproductive patients. The clinical diagnosis is not too great a factor in their selection. Emphasis is placed on selecting those patients whom we feel will respond to and benefit from a group situation, therapeutically oriented."

From a children's agency:

> "Children not so disturbed as to be unable to relate to others in a group; i.e., neither too withdrawn nor too aggressive. We attempt to achieve a balance between passive and aggressive types."

From a psychiatric clinic:

> "We say we have criteria, but we can never agree on them. We attempt to achieve 'balance' in our groups; i.e., mix 'talker' with 'silent' patients. We do not pay a great deal of attention to diagnostic categories. We try to select patients who can benefit by a group experience. Withdrawn, isolated, unemployed, single, male schizophrenic patients fall into this category."

In this last description, one might say that the question of selection for groups had come full cycle: from dissimilarity of observable behavior to similarity of diagnosis—where the latter had not been intended.

Finally, psychiatric hospitals reported use of the group method for personnel: nurses, Ph.D. candidates in psychology, attendants, and medical students.

GOALS AND LEADERSHIP

Four types of groups emerged from the survey. They could be roughly classified as: Activity; Information-Giving; Limited-Goal Therapy; Intensive Therapy. Goals were correspondingly varied. The leader's role seemed to depend both on the purpose for which the group was formed, and on his skill backed by his individual interest and experience.

In the Activity Groups the survey committee included both play sessions and psychodrama or sociodrama. The leader's role in the play groups with children or adolescents was usually seen as the permissive, giving, and protective parent. For instance, in a psychiatric clinic, the leader of a group of adolescent girls described her part as being to "understand and meet as realistically as possible dependent needs through refreshments, equipment, carfare, etc.; to help them to use the group

process and interaction, verbal and nonverbal; to test new patterns of behavior." Apparently, in most such groups, interpretation of content or behavior by the leader was rare.

In groups using psychodrama or sociodrama, the leader often deliberately played a part: mother, father, sweetheart, spouse. One social worker wrote that the more wholeheartedly she played her role, the better the patients could enter into the spirit of the group. Other leaders stood apart from the drama, at first assigning roles, then permitting group members to select their own. Frequently, role-playing was dropped as the group solidified, and discussion was substituted for acting.

The Information-Giving Groups typically focused on a specific topic which the leader supplied for the group to discuss. The leader was essentially a teacher. His job was to inform; his hope was that such information would remove prejudice, allay anxiety, free group members for wiser action. Like any good teacher, he encouraged discussion and airing of opinions.

Family and children's agencies sometimes used this group method for explaining agency policy to parents or foster parents, and occasionally provided leadership for already established groups in settlement houses, churches, or the P.T.A. General hospitals formed groups to explain a specific disease, such as polio or cerebral palsy, to patients and to relatives. Psychiatric hospitals occasionally invited relatives to see and discuss films on mental hygiene. One social worker using this method reported clarifying and interpreting "simple psychodynamics" in this connection. Another spoke of providing lists of suggested reading.

One illustration from the psychiatric clinic of a general hospital might serve to describe how the information-giving groups were usually conducted:

> "Meetings of parents of children with rheumatic fever are planned around topics such as discipline, the physically handicapped child, sex education. I focus the beginning of the discussion and keep it goal-directed. At the same time the group discusses the topic at their level, raising and answering their own questions. I help to clarify within the group and with individual members in relation to themselves and their families."

In Limited-Goal Therapy Groups, the leader used material fashioned from the personal experiences of the members and encouraged them to express their feelings about the content. Through the conscious use of himself, he enabled members to form purposeful relationships with him and with one another. By drawing analogies between the responses and interactions of the members, he tried to promote their self-awareness. He set limits and focused the discussion.

From the leader of a VA mental hygiene clinic group composed of psychosomatic patients came the following description:

> "My role is to enter into the discussion at any point to sharpen or clarify interaction. I attempt to have patients look at what they are doing at the moment they are doing it, in order for them to recognize how their feelings about themselves or others affect their illness."

From the leader of a mothers' group in a psychiatric hospital:

> "My role is to lead the group in discussion of the experience they are living through, of having a relative a patient in a mental hospital—its meaning to them and their social circle. Also to examine their relationship with the patient and find out how there might be something better between them. Also to help them see the patient as being less different, and with the same feelings and reactions as theirs."

In a child guidance clinic, the mothers of young boys with school problems were "encouraged to express their own feelings about another mother's handling." In a children's agency, the leader described her method with a group of adolescent girls:

> "My activity is directed toward helping them to understand some of their reactions and feelings which caused them to get into trouble. I encourage them to tell about their relationships and feelings towards their families. With some help from me at times and from the members, too, several of the group have become aware of ways in which they contribute to their conflicts with others. Occasionally I take a position on what is socially acceptable behavior and why."

The leader's role as described in the Intensive Therapy groups was different. Here he saw himself as encouraging catharsis, and active in exploration of resistance and defenses, especially when these blocked group movement. He emphasized transference and countertransference elements. At times he deliberately fostered identification with himself. He actively promoted group interaction, set few limits, and focused to a minimum degree.

Two leaders of groups in psychiatric hospitals gave these summaries of their work:

> "My role is to stimulate communication, bring out areas of common concern, control interaction, encourage participation by withdrawn patients, control excessively aggressive action, synthesize insight, provide interpretation, accept hostility and negative reactions directed at me, and reflect back attitudes and feelings emerging in the group process for the members to examine." (This group had met 50 times.)

> "I encourage the patients to accept reality and develop insight through communication. I have slowly brought about dissolution of transference from a protective, permissive father, to reassurance, interpretation, and expansion of reality. Inherent in this process is the necessity for me to be aware of latent content of the material, the anxiety, resistances, hostilities, etc. This implies that I gave direction, avoiding distress and acute anxiety whenever necessary." (This group had met 28 times.)

Social workers stressed in their reports the need

for understanding of the unconscious meaning of members' verbalizations and behavior. Some of them also mentioned interpreting such material to the group. For example:

> "In a group of ambulatory schizophrenics in a private clinic, I encourage all members to recognize and express their feelings and to give interpretation for themselves and others. If they do not help in the exploration, I give support and some additional information. When appropriate, I give interpretation of quite deep, unconscious material."

The survey committee was also interested in the role of the coleader. But of the 80 sufficiently explicit descriptions given in the questionnaire answers, only 21 fitted the acceptable definition of "equality of value, function, and place in leading the group." The rest were chiefly occupied with observing, recording, assisting with practical arrangements, and occasionally acting as substitute leader in the regular leader's absence.

RECOMMENDATIONS

The pilot study and survey revealed widespread use of psychiatric social workers as group leaders in varied settings and roles. The committee concluded that they have indeed a real contribution to make in this field. However, it recommended special training and experience in group theory, method, and practice for all who intend to lead therapeutic groups, and urged that schools of social work assume leadership for teaching.

The committee also recommended that teachers and practitioners develop a more specific body of knowledge regarding the techniques of leadership and the selection, duration, purposes, and methods of group treatment. •

Nurses and Psychotherapy

By JACQUELINE BERNARD
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FOR THE PAST YEAR I have enjoyed a rather unusual alliance with the nurses in the state hospital where I am employed as a psychologist. These nurses, my close coworkers, are psychotherapists; they carry the largest share of responsibility for our hospital's program of group therapy. This is a controversial state of affairs, and I speak of it not apologetically, but proudly, because we are successfully utilizing our nurses' talents in a way that is generally considered to be unorthodox.

Our hospital houses about 1,100 patients at any given time, and we rarely, if ever, employ more than six trained psychotherapists. Among those on our staff who have received prior training in psychotherapy are the superintendent, who is our only board psychiatrist; the chief of social service, and sometimes another social worker or two; the chief psychologist, who divides his time between the psychology and clinical research units; and myself. Most of the time I have been the hospital's only other psychologist. If the hours each of us has available for psychotherapy were added together, the total would be so small as to make formal psychotherapy practically nonexistent among our treatment services. Of course, the informal psychotherapy offered by our ward physicians is invaluable to our patients. But it is not enough.

I assert that psychotherapy in a state hospital should not be regarded as a "special" endeavor. It is implicit in the total treatment program. If this assertion is granted, there is no reason why nurses cannot discharge their assigned duties, and, after proper training, act as psychotherapists as well. Naturally, the techniques and immediate purposes of psychotherapy are somewhat different from those inherent in other patient-nurse contacts. These differences, however, are superficial. Psychotherapeutic techniques and purposes can be learned by *any* would-be therapist who possesses the fundamental capabilities required to carry out the nonpsychotherapeutic aspects of his job.

NECESSITY INSPIRES ACTION

I can support my assertion by relating our recent experience in developing a psychotherapy program at the Anoka State Hospital. We wanted to offer psychotherapy to our patients, but did not have a sufficient number of therapists to do so. Then we learned that members of the staff of the Willmar State Hospital, also in Minnesota, were being trained to do group therapy, regardless of their established professional roles. This seemed to point the way to a solution to our problem.

Of course, Willmar Hospital was better staffed than Anoka, and its group therapy program had an aura of orthodoxy because it was conducted largely by psychologists, who are generally expected to devote at least some portion of their time to psychotherapy. However, it had a touch of radicalism too, since some of the therapists in training were chaplains or members of the recreation staff.

At Anoka, we could be orthodox only to the extent that we had one psychologist available to direct a psychotherapy program and train its therapists. From that

point on, we knew we had to depart from tradition if our program was to serve a worthwhile number of patients. At the time, all departments in our hospital were understaffed. We could justify diverting the time of our busy professionals only if we could anticipate from the program either direct patient benefits in the form of improved care or indirect employee benefits in the form of increased general competence.

We initiated the program by inviting interested professional personnel to attend orientation meetings in which group therapy techniques would be discussed and illustrated. We made no effort to concentrate recruiting efforts on any particular department, but sent notices to all ward physicians, chiefs of social service, nurses, and rehabilitation therapists. We told them that we would select therapists from among those who, after exposure to the techniques, expressed a desire to receive further training. I expected, from observing the Willmar experiment, that there would be a good turnout for the orientation meetings, and there was.

TRAINING BEGINS

I selected several staff members who had participated most freely in the meetings to assist me in the first training-therapy group. The others were invited to participate as observers, if they wished. I fully expected to lose all but a few of our potential therapists when we actually began to work with patients. So I was agreeably surprised, when I arrived at the first training therapy session, to find myself confronted with as many participant-observers as patients. One whole row of the observers was white-uniformed and capped. To make this turnout possible, the nursing supervisors were filling in wherever needed so that ward front-liners could attend the meetings. Shortly afterwards, they arranged for student nurses to observe one or more meetings as part of their affiliate training.

At least 12 meetings were attended by nurses and aides representing almost all hospital areas—the TB unit, the medical-surgical and the geriatric wards, and the acute-intensive treatment and continued-treatment areas. During the first eight months of the program, before summer vacation schedules cut into attendance, several ward charge-nurses had been released from their regular duties to attend as many as 35 hour-and-a-half meetings. The assistant director of nurses had been with us for all but the first six weeks of the program, and the entire nursing education staff had participated from the beginning.

Throughout this early period, staff members who stayed with the program were drawn into increasing and increasingly varied participation. They were encouraged to enter into discussions, to portray roles with the patients, and eventually to lead the group. Eight months after we started, our single group had expanded to four, all functioning relatively independently. My own group continued to combine training and therapy; each of the others was headed by one of our "homemade" psychotherapists.

At present, nurses are active in three of the groups. The assistant director of nurses works with me as junior leader, and we are assisted by a licensed practical nurse and a chaplain. The supervisor of the nursing education unit leads a second group, with a member of her staff (an instructor in the student affiliate program) as junior leader, and a ward nurse as assistant. The third group is headed by two other nurse educators, who are assisted by a psychiatric aide. A recreational therapist leads the fourth group, with the help of another recreational therapist who is junior leader.

I maintain supervision of the program by meeting with the leaders regularly for an hour each week, and by consulting with them whenever necessary. These meetings and consultations provide all of us with the opportunity for a continuing cross-fertilization of ideas and development of techniques.

Forty patients, which is the number we are prepared to serve at one time, are not a great many out of 1,100. It is, however, a considerable addition to the number who would be involved in formal psychotherapy if we did not have our new program. Patients assigned to it represent all hospital areas and a wide range of disability: the 12-year-old delinquent, the 14-year-old schizophrenic, the woman in her 40's who has been with us for eight years, and the man in his 60's who attempted suicide and achieved brain damage instead.

"UNORTHODOX" PROGRAM SUCCEEDS

While it is not the purpose of this paper to elaborate on our psychotherapy program's philosophy or its techniques, I should mention that none of us believes psychotherapy is magical in its effect. We use it as one more means of moving patients toward attitudes and behavior that are acceptable and constructive. We attempt, deliberately and openly, to stimulate constructive use of the daily hospital experience. In doing so, we draw upon the observations of physicians, ward personnel, rehabilitation therapists, industrial supervisors, and social workers; we also obtain information from daily reports and medical charts. In this way we get a clear picture of what is affecting the patient day by day, and of his observable reactions within his hospital world.

By the end of another year it is conceivable that our cluster of leaders will have increased, and that we will be offering psychotherapy to 80 patients at one time. A meaningful evaluation of direct patient benefits stemming from this program must be delayed until then, but already we believe that the indirect benefits of the program have been considerable. These include:

1. Enhancement of the hospital's educational program, not only for students (directly and through their instructors), but also for some employees for whom the program serves as a continuing inservice training resource.

2. Increased job satisfaction for some of the hard-pressed ward nurses and aides who usually work in relative isolation with chronic or severely disabled patients. One aide, commenting on her experience as a participant-observer, put it this way: "It gives you something to think about besides custodial care."

It is true that nurses often have relatively inflexible

schedules that prevent them from participating in extra activities. Beyond such a practical consideration, however, by what standard should nurses not be psychotherapists as well? When we look objectively at the issue of who is to do what part of a hospital's task, few professionals of any discipline can argue that any one with a gift for making contact with patients and acting as a catalytic agent in their interest should be prevented from doing so.

Issues of this kind, unfortunately, are not always viewed either objectively or practically. Those who are trained in psychotherapy are sometimes reluctant to see the term included in the job descriptions of other professional groups, despite an obvious need for more psychotherapists. Conversely, many whose job descriptions do not mention psychotherapy are often horrified at undertaking a function not included in their professional curricula. Then again some professional groups which are in the process of defining functions hesitate to include any task which cannot be performed by all. For reasons such as these, I fear, some who would be excellent therapists—and who also wear white caps—will be prevented from serving their patients more completely through training and experience in psychotherapy.

As for our own staff, there has been remarkably little adverse reaction to the new role some of our nurses have assumed. We refer to our new psychotherapeutic approach as the "psychodrama program," although we use only the techniques and not the theoretical framework of psychodrama. Those of us who are engaged in the program are called "group leaders." By such simple manipulation of terms we have avoided some of the objections that might have been made.

However, our choice of a name for the program is not solely responsible for its favorable reception; our superintendent's understanding of our plans and goals is the principal factor in its success. I have already mentioned the strong support given by the director of nurses, who supplied staff members to challenge and stimulate us and to become our future group leaders. Also, when I presented an outline of our intentions to my own department head, I received permission to proceed even before plans were discussed with the staff. Without such understanding and approval at the administrative level, our attempt to move away from tradition through our new program would have been impossible.

I have learned a great deal from my nurse coworkers. At first, infused as I was with professional pride, I was astounded by the sharpness of their perception and the flexibility of their approach. My astonishment has long since changed to appreciation of the nurses' talents, and I realize that our cooperative efforts in psychotherapy have benefited all of us. My own experience leads me to recommend a program of this kind to other state hospitals that suffer from a chronic lack of psychotherapists. •

Have You Heard?

TRAINING: Physicians everywhere are notorious for their poor handwriting. Being aware of the hazards of cacography, somebody has decided to do something about it. Mount Sinai Hospital in New York City is currently offering a course in *penmanship* for all medical and paramedical staff in collaboration with the Handwriting Foundation of Washington, D. C. This is in the way of an experiment. The results of this project will be made available by the Handwriting Foundation and the hospital to educators and medical personnel throughout the country.

The *Western Mental Health Training and Research Council* of WICHE has received a grant of more than $150,000 from the National Institute of Mental Health. This grant will support a three-year project to expand interstate training programs for staff of mental hospitals and schools for the mentally deficient. Three program elements will be involved: (1) Regional conferences on techniques of inservice training, administration, and therapeutic aspects of staff-patient relationships; (2) Visits of personnel to hospitals in neighboring states where outstanding projects are under way; (3) A regional education program on a continuing basis which will bring university teachers to the institutions to conduct periodic workshops and training programs.

REHABILITATION: The *Massachusetts Association for Mental Health* has been awarded $25,000 by the Federal Government for the first year of a three-year project and study on the employment of selected ex-mental hospital patients. About 20 per cent of discharged patients are unable to find or hold jobs; this study will attempt to determine whether these ex-patients are employable and, if so, whether employment will help them maintain their recovery. The project hopes to demonstrate that those who are successful in their work will have fewer relapses and shorter stays if they do return to the hospital.

Priority in the selection of ex-patients will be given to those who have had long periods in mental hospitals; who have been hospitalized more than once; who have no families to return to; and to those with continuing emotional problems. The staff will include a psychologist, a psychiatric social worker, and a psychiatric employment specialist. Each person in the study will have one particular staff member with whom he will work and who will help him to achieve satisfactory rehabilitation.

In addition to the service program, the project will collect information on the estimated cost of aftercare services, and the possibility of shortening hospitalization for long-term patients. Cooperating in the project, directed by Dr. Samuel Grob, are the State Department of Mental Health, the Center House Foundation, and the Massachusetts Rehabilitation Commission.

AMERICAN PSYCHIATRIC ASSOCIATION PUBLICATIONS

STANDARD REFERENCE WORKS

Diagnostic and Statistical Manual, Mental Disorders . . . Prepared by the Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952 ..... $2.00

Standards for Psychiatric Hospitals and Clinics, 1956 Edition (revised June 1958) for Public and Private Hospitals, Psychiatric Units in General Hospitals and Hospitals & Schools for the Mentally Defective $1.00

An Outline for a Curriculum for Teaching Psychiatry in Medical Schools ..... .25

SPECIAL CONFERENCE REPORTS

Psychiatry and Medical Education . . . Report of the 1951 Conference on Psychiatric Education held at Cornell University, organized and conducted by the A.P.A. and the Association of American Medical Colleges, 146 pp., cloth, 1952. (Formerly $1.00)
The Psychiatrist—His Training and Development . . . A substantive report of the 1952 Conference on Psychiatric Education, and a companion volume to "Psychiatry and Medical Education." (Formerly $2.50)
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Design for Rehabilitation in Australia

By E. CUNNINGHAM DAX
Chairman, Mental Health Authority
Victoria, Australia

SINCE 1952, the state of Victoria in Australia has been reorganizing its Mental Health Services to provide a more effective treatment and rehabilitation framework for returning psychiatric patients to the community as soon as possible. The theory behind the program is that "there are no chronic illnesses, only chronic hospitals."

Victoria occupies the same latitude south as Kansas does north, and is similar to Kansas in size. Of its total population of 3,000,000, almost 1,800,000 live in the city of Melbourne. By constructing regional psychiatric units and adding rehabilitation wards to existing mental hospitals, Victoria seeks to:

1) Make it possible for any person to obtain psychiatric help within a reasonable distance of his home. Psychiatric units are being built in five rural areas, each with from 150,000 to 250,000 residents, and in four metropolitan divisions, each with a population of 400,000 or more. The regional services will function as centers for early treatment and as headquarters for local community psychiatric programs.

2) Satisfy the psychiatric needs of a population which is increasing by 75,000 each year.

3) Provide additional facilities to accommodate an excess of 2,000 patients in mental hospitals.

CONCENTRATION ON REHABILITATION

According to current professional opinion, inpatient care soon will be no more than an episode in the total treatment of patients, after which many will return to the community. However, present knowledge indicates that, inevitably, some patients' behavior will make their departure from the hospital impossible. Others will be able to leave only if better hospital rehabilitation and broader community services are available; these are *rehabilitation patients,* traditionally described as "mental hospital" patients.

There are two groups of rehabilitation patients: those who fail to recover with short-term care and are not well enough to live outside the hospital; and those now labeled as "chronically sick," who have spent long periods in mental hospitals and have institutional disabilities superimposed on their original illnesses. These groups are divided arbitrarily by including in the second category only patients who have been hospitalized two years or more.

Victoria is building three types of rehabilitation wards (referred to as A, B, and C) for both groups of patients. The design and function of the three wards promotes the progressive improvement of patients by helping to regulate their treatment through environment. A and B wards are being added to mental hos-

pitals where essential treatment services are already available. Type C wards are being built in conjunction with the new regional psychiatric units to meet the needs of the least chronically ill patients in the first group. Patients on these wards will not have been exposed to "chronic" mental hospitals.

WARD DESCRIPTIONS

Type A—Designed in 1954. Eight of these 45-bed wards have been built at Larundel Hospital in the northern Melbourne suburbs. They are modifications of an earlier plan which restricted them in design because the basic dimensions had already been determined.

Some of the favorable features of the A ward are: inexpensive brick construction, good lighting, excellent offices for doctors and nurses, good day-room observation, small dormitories, and several single bedrooms. However, Type A has the following drawbacks: lengthy construction period, two-story design, excessive corridor space, occupational rooms attached to the ward, 45 patients being together in the dayroom without subdivision, no division of bathing and washing blocks, poor facilities for group organization, long walks for staff from one part of the ward to another, and unsatisfactory communication facilities.

Type B—Designed in 1955. In Victoria, a large number of school buildings have been constructed of concrete veneer. They consist of two 24-foot-wide buildings, separated by a corridor eight feet wide. Because of the urgent need to alleviate overcrowding in the mental health department, B wards were constructed according to the basic design of the schools since many contractors were experienced in erecting the schools, and the materials were readily available. These 36-bed wards have some interesting features. All the plumbing is grouped in a central area on a concrete slab. One corridor runs the length of the building and another crosses it in the center; therefore, wards can be connected when placed end to end, or side by side.

Twenty of these wards have been built so far and are very popular with staff and patients. The points in their favor are: simplicity of design, adequate dormitory accommodations, sufficient fittings and plumbing arrangements, very easy maintenance, good accommodations for staff, good observation, cross-communication with other wards, and inexpensive and rapid construction. Their disadvantages are: low toilet-to-patient ratio, mass washing, no grouping within the dayrooms, no single rooms, no rooms suited to group discussions, high elevation from the ground, and too much glass to clean.

Type C—Designed in 1959. The first four of these 48-bed wards are being constructed as part of the regional center at Traralgon, in an industrial area 100 miles from Melbourne. This design incorporated new principles because it was limited only by cost. The dormitories are in two-story buildings, and the dayrooms are single-story. C wards are constructed of steel and concrete, and have glass panels and aluminum frames.

Patients in C wards will be more independent than those in other types, and will require greater self-government. Instead of being exposed to a traditional mental hospital, they will pass through a new psychiatric unit on the way to the rehabilitation wards, and will be conditioned to living in small groups.

C wards are easily converted to use for both sexes; the males sleep on the second floor and females on the first. Cloak rooms, toilets, and laundries can be divided between the sexes. The wards provide discussion and meeting areas, bathing facilities, cafeteria, general workshops, single rooms, minimal corridors, and laundry and washing areas. Ward space allows for one patient to a cubicle, six patients to a washing area, twelve in a dormitory unit, and sixteen in a dayroom (space for 48 is divided into three areas).

The wards will give the patients greater freedom and less "hospitalization," and also a better opportunity for organized group living. In general, they are designed to protect the patients' privacy as much as possible; the patient-to-toilet, -bath, and -shower ratios are lower than in A or B wards, and there is more dormitory and dayroom area per patient. Yet, the cost per bed is the lowest of the three, because of economy of construction.

Type C wards should show whether real progress

Type A Ward, of two-story brick construction, accommodates 45 patients. It is one of three kinds of rehabilitation wards being built in Victoria.

can be made by planning a building which requires its occupants to have responsibility, freedom, and a progressive plan of group living. The staff may find it difficult to adjust at first, particularly if they have been trained in conventional mental hospitals, but a full explanation of the reasons for constructing the buildings should help to insure the wards' proper use.

The essential principles of psychiatric rehabilitation for inpatients on which these three wards are based are:

A) Treatment

For rehabilitating patients, treatment needs to be directed more toward adjustment to or elimination of symptoms than to recovery. Much of the psychotherapy will follow simple group methods; physical treatment by drugs and other procedures will be used primarily to aid rehabilitation.

Therefore, the doctors' and ward sisters' rooms in a rehabilitation ward should be large enough to interview a number of people at once, whether patients or staff. An adjacent clinic is also essential for examinations; physical treatment; and storage of drugs, records, and apparatus.

The sisters' room should provide good observation and be easily accessible to patients. It can be used for clinical work, interviewing patients, and staff communication and training. This room should be separate from the sisters' staff offices and retiring rooms.

The dayroom should be divisible into areas suitable for group meetings, varied according to therapeutic requirements. Folding doors, movable furnishings, and groups of lights controlled by different switches assist in making such subdivisions.

B) Industrial Rehabilitation

In Type A wards this is done partly on the premises; in Types B and C it takes place in separate, occupational or industrial centers. The design and organization of these activity centers, wherever they are, should approximate a typical factory for light assembly work. Provision and storage of proper work clothing is necessary, and adequate bathing and laundry facilities should be on the wards.

C) Resocialization

Ward design must emphasize this most important of nursing activities in rehabilitation. Most patients have social problems, whether in relation to their families, neighbors, or co-workers.

It is remarkable that so many seriously ill people manage to live and work in the community while others who are comparatively mildly ill are forced by opinion to be in the hospital. Sick people seem to be tolerated in the community if they have some hypothetical sociability factor, and are ostracized if they lose it. Perhaps it would be wiser to try to find this "community factor" in the treatment of long-term patients than to concentrate upon the removal of their symptoms. Patients often can acquire this factor in a therapeutic community where people are encouraged to live together in groups. Here they learn to help each other, are wanted, respected as individuals, and feel they belong to a group whose mutual aim is recovery.

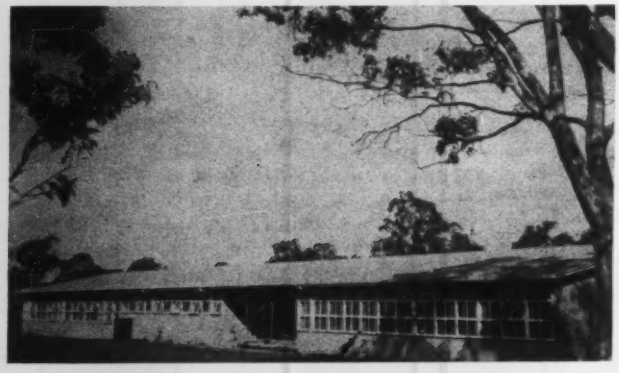
Therefore, these wards must be designed primarily for group organization and living. They should provide for individual privacy, although they contain small groups of from four to twelve people. The word unit is formed by a number of these groups, but within it there also will be smaller groupings of patients who have common interests.

In this respect the World Health Organization states, "To develop his relationship with his environment every effort should be made to enable the patient to develop from isolation to community life, from a complete dependency to independence, and from restriction to freedom."

D) Freedom

Experience shows that it is easier to give patients freedom if they start their treatment in open wards. If certain safeguards are adopted, it may be assumed that the better the wards, the better they will be kept; the larger the windows, the less likely they are to be smashed, etc.

This does not mean that precautions can be completely ignored. Patients still hang themselves in lavatories, have homosexual and heterosexual relationships,



Design of Type B Ward follows that of concrete-veneer school buildings which are popular in Victoria. The ward houses 36 patients on one floor.

scald themselves, raid the medicine cupboards, have fits, become deluded about one another, or interfere with the public peace. So it is desirable to have head-high lavatories, bathroom walls, and doors; regulated water temperature; modified central air heating and cooling instead of open fireplaces; large-size observation panels to sing rooms; walls glazed above shoulder height; and outside doors that can be locked at night.

E) Return to the Community

The community rehabilitation of patients is more successful where there is public interest, understanding, and assistance in their reintegration into the world outside the hospital. The community, therefore, should maintain contact with the hospitals wherever possible, especially where a new unit is being built.

Since visitors usually prefer to see patients in the common rooms such as the library, hall, or cafeteria, visiting rooms have not been included in any of the designs. Keeping the public away from the wards by shunting them into visitors' rooms only adds to their fears and preserves the "mystery" of mental treatment. However, provisions should be made for patients to have visitors on the wards, if need be, without interfering with the other occupants' privacy. Here again, movable furniture is of value, and small kitchens should be available for such entertaining.

VIEWPOINTS ON DESIGN

All wards are limited in their design by the viewpoints of interested people: the government authority financing the hospitals, the public, the psychiatrists, the staff, the architects, and the patients. The patients are named last because while all the planning is done for their benefit and the wards are designed to rehabilitate them, the best of aims may directly oppose their wishes. Planners can only hope that their faith in themselves to impose a structure and a way of life on the patients for their own good is not entirely misguided.

The government is interested in the cost, maintenance, and permanence of the buildings; flexibility of design; and number of staff needed to run them.

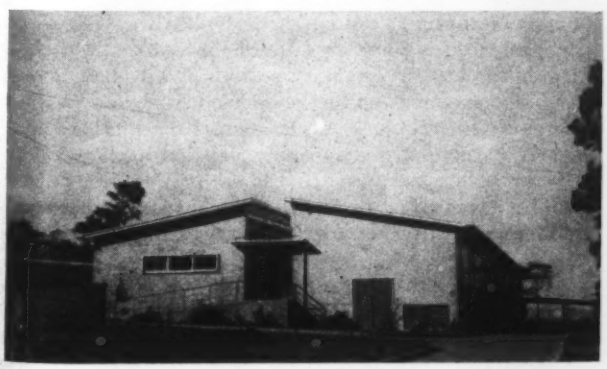
Public reaction to a new hospital is apt to be antagonistic unless people in the neighborhood are carefully prepared for the advent of a hospital designed to give considerable freedom to patients. Publicity helps the local community to identify with the hospital and its purpose.

Psychiatrists must explain to the architect what sort of patients they are going to have, how they plan to treat them, and how the building can best serve their purposes. A good design will promote an orderly and constructive way of living and contribute towards the formation of the therapeutic community.

The architect draws his plans to meet the needs of the people concerned, but he needs full information and cooperation to produce the best results. This necessitates frequent meetings between the psychiatrist and architect, who must work closely together. The plans should then be considered by and modified according to the requirements of the other people concerned in the patients' treatment. Then they should be reviewed and discussed by all parties concerned.

The nursing staff needs clinical stations; security cupboards for drugs; provisions for clean and soiled linen; adequate lighting, heating and water; cleaning devices; and their own toilets and lockers. The ward design should reduce the distance nurses have to walk, and offer good though unobtrusive observation throughout the ward. Staff anxiety is reduced by providing for the safety of ward stock, and by avoiding irritating frustrations because of faulty ward design.

In the final analysis, patients are in the hospital to be rehabilitated, not to find a home away from home. Yet at the same time, it is not difficult to remove objectionable features in their lives if the wards are organized for therapeutic purposes. For instance, most patients resent lack of privacy, noise, institutional cooking and feeding arrangements, sparseness of washing and toilet facilities, smells, community bathrooms, and lack of personal lockers and wardrobes, which are all too often a part of institutional life. Over-concentration of people, long corridors, and locked doors—these are all matters of dissatisfaction which can be remedied for the purpose of rehabilitation.



Side view illustrates central corridor which conveniently separates B Ward into two buildings. Flexible facilities please staff and patients.

REVIEWS & COMMENTARY

BOOK REVIEWS

Last month we reviewed two of four films which comprise a new series issued under the general title, THE DISORDERED MIND. These two films depicted a psychosomatic condition and a psychotic depression. The remaining two films, reviewed below, deal with a case of pathological anxiety and a psychopath. The series was produced by Robert Anderson, with H. E. Lehmann, M.D., serving as consultant. Originally shown on Canadian television in 1960, these films are now available in 16mm. Purchase and rental information may be obtained by writing to the distributor: International Film Bureau, 332 South Michigan Avenue, Chicago 4, Illinois.

Three who help to shed light on the workings of "The Disordered Mind" are (from left) Robert Anderson, moderator for the series, and two Canadian psychiatrists, Nathan B. Epstein, M.D., and H.B. Durost, M.D.

A PATHOLOGICAL ANXIETY (black and white, 30 minutes) Produced by Robert Anderson Associates, Ltd.

TO ILLUSTRATE the nature of the psychoneuroses, this film presents the case of an office worker whose emotional disorder went unnoticed for a long time until one day he found himself unable to leave the house and go to work. For three years, his feelings of terror and panic prevented him from leading a normal life. As we watch the patient in a series of interviews with his psychiatrist, A. M. Marcus, M.D., we hear him describe his attempts to "bottle up" his feelings of rage because he fears he might suddenly give in to "sudden impulses" to lash out at other people. These psychiatric interviewing sequences are especially interesting because this patient is highly articulate; as his psychiatrist points out, he sets up a screen of words to hide the feelings he fears.

Psychiatric comment on this case is provided by Nathan B. Epstein, M.D., who does an excellent job of explaining the workings of the unconscious mind and other factors relating to the anxiety disability. He points out that this patient has withdrawn, on a symbolic level, to an infantile state because he could not handle his feelings of hostility. Healthy people learn how to handle and control the urge to rage—an urge that is basic in everyone but is curbed by society's taboos. In this patient, his fear of "losing control" was a distortion, and his efforts to suppress his hostile feelings resulted in an almost complete withdrawal from life.

Like the other three films in this interesting new series, "A Pathological Anxiety" could be shown to the general public. Unlike the others, it would probably not be a good film to be followed by a discussion. It contains so much loaded content that a discussion leader would have to be very skillful to keep the discussion within bounds. This film could, however, be followed by a speech by a psychiatrist exploring other aspects of the problem of acute anxiety. Probably its best use will be with medical, nursing, and social work students, although professional staffs of mental hospitals would also find it an absorbing half-hour.

A PSYCHOPATH (black and white, 30 minutes)

WHAT MAKES a highly intelligent young man, with a charming manner and persuasive personality, commit a burglary and then brag about it so that capture is inevitable? One answer is that he may be a psychopath, constitutionally unable to distinguish right from wrong. Mr. Anderson reconstructs one such case through a series of fascinating interviews with the patient himself, with a detective, with the director of a rehabilitation service, with the deputy warden of a federal training center, and —most revealing of all—with the psychiatrist.

The patient recounts his eventful career on the fringe of "respectable" society in a somewhat smug though disarming way. As his psychiatrist, H. B. Durost, M.D., points out he appears to know all about himself, yet he does not really have any insight into his difficulties. Like many psychopaths, this patient has a flair for histrionics—to judge from the obvious relish with which he describes his adventures. In explaining the "why" of the psychopathic personality, Dr. Durost advances the idea that psychopaths are basically irresponsible people who in childhood did not have the opportunity to establish meaningful relationships with others. He likens the emotional instability in such people to the condition of cerebral palsy in childhood. Despite a certain amount of training, the condition will always be there. The prognosis is very doubtful because of the lack of adequate treatment facilities, as well as a lack of knowledge. Society must protect itself from such persons, but where do they belong, in a mental hospital or in a prison? Psychopaths are usually shuttled back and forth between police and psychiatrists without anything being done for them. The disquieting conclusion is that there are still many psychopaths, in many walks of life, who have not been apprehended for any crime and who are perhaps unaware of their tendencies.

There are many remarkable things about all four of these films. The technique of presenting the material through brief discussions between the patients and their

psychiatrists, with additional psychiatric commentary supplied for further enlightenment, is immeasurably more effective than any dramatization could possibly be. One is always aware that this is the "real thing," although, of course, there must have been a certain amount of staging since the patients were conscious that they were being photographed. All four cases are interesting per se as well as being perfectly illustrative of the four different kinds of mental illness discussed in the films. Because of the sensitive way in which the psychiatric interviewing scenes are handled, these films would be valuable training aids for students in any medical or psychiatric training center. They would also be useful in programs of education with various "publics" in the community. The last film, "A Psychopath," would be especially valuable for action groups to use in community campaigns for more psychiatric services to work with civil authorities in cases where crimes are committed by mentally disturbed persons.

JACK NEHER
Mental Health Materials Center

BOOK REVIEW

MENTAL RETARDATION—PROCEEDINGS OF THE FIRST INTERNATIONAL MEDICAL CONFERENCE AT PORTLAND, MAINE—edited by Peter W. Bowman, M.D., and Hans V. Mautner, M.D., New York, Grune & Stratton, 1960, 530 pages, $12.50.

This volume contains in full the 58 papers presented at the First International Medical Conference on Mental Retardation in July, 1959. It is divided into five parts to conform to the program of the conference, includes a summary of discussion highlights, and is profusely illustrated.

Part one consists of six papers on developmental, experimental, anatomical, and physiological background information; part two, eight papers on various aspects of developmental brain damage due to injury, infections, biochemical errors, etc.; part three, ten papers on neurochemistry; part four, nine papers from the standpoint of clinical neurology; and part five, five papers from the standpoint of clinical psychiatry.

A reviewer cannot do justice to such rich material when forced by limited space to select only papers of unusual interest for comment. This selective process, however, does not reflect negatively on the caliber and importance of papers which are not mentioned here; all are valuable and worthy of attention.

The book contains many fine contributions concerning the basic sciences. The opening paper, "Anatomy of the Human Brain and the Problem of Mental Retardation," by Paul I. Yakovlev, M.D. (Harvard), is particularly thought-provoking. This dynamic approach to developing mental neuroanatomy will lead to new ways of investigating the unknown. David Yi-Yung Hsia, M.D. (Northwestern University), contributed an excellent report on "Enzyme and Mental Deficiency."

In part two, the most important articles, in this reviewer's opinion, are "Complications of Pregnancy and Mental Deficiency," by Hilda Knobloch, M.D., and Benjamin Pasamanick, M.D. (both from Ohio State University); and two papers dealing with infection and its role in the field of mental retardation—one by Hans Asperger, M.D. (University of Innsbruck, Austria), and the other by J. Sutter, M.D. (University of Alger, France).

The third part deals with a variety of problems in neurochemistry, and the influence of biochemical errors on brain development. Readers looking for practical, tangible information on the status of progress in this field will benefit from the clear, concise, and objective report, "The Dietary Treatment of Phenylketonuria—Experiences During the Past 9 Years," by H. Bickel, M.D., and W. Grueter (both from the University of Marburg, Germany).

In part four, there is an excellent summary on mongolism by Clemens E. Benda, M.D. (Walter Fernald State School, Mass.), who is a well-known authority in this field. This is a thorough, careful report of the author's investigations. There are two other exciting papers in this section. One is by Paul E. Polani (Guy's Hospital, London), on "Chromosomal Factors in Certain Types of Educational Subnormality." He reports on the breakthrough in our knowledge of chromosome disturbances, and summarizes what is known about them, referring to important discoveries, such as those made by co-workers in England, and by Lejeune and his collaborators in

France. The other equally intriguing contribution is "Infants' Vocalizations and Their Significance," by Samuel Karelitz, M.D., Ruth Karelitz, and Laura Rosenfeld, M.A. (Department of Pediatrics, Long Island Jewish Hospital). However, the reader may not grasp the paper's full significance since he cannot hear the sound recordings and tapes which accompanied its presentation at the conference.

In part five, papers by Lauretta Bender, M.D. (N. Y. State Department of Mental Hygiene) and Clemens Benda, on childhood schizophrenia, are most interesting. The authors summarize our present knowledge of this subject and controversial theories concerning it. P. H. Gates, M.D. (J. J. Putnam Children's Center, Boston), reports on "Etiology and Treatment of Atypical Development in Children." G. E. Gardner, M. D. (Harvard), presents his ideas on "Mental Retardation as Part of the Training Program in Child Psychiatry," and Hans Asperger, M.D., discusses "Behavior Problems and Mental Retardation." Gardner's thoughts regarding training for child psychiatry should be brought to the attention of all training directors of psychiatric residency programs. Perhaps they will induce more child psychiatrists to demonstrate their interests in this field at a future conference.

The medical profession is to be commended for expressing interest in mental retardation by arranging and attending this first international congress, organized so capably by Peter Bowman and his associates. The second international congress will take place in August 1961 in Vienna.

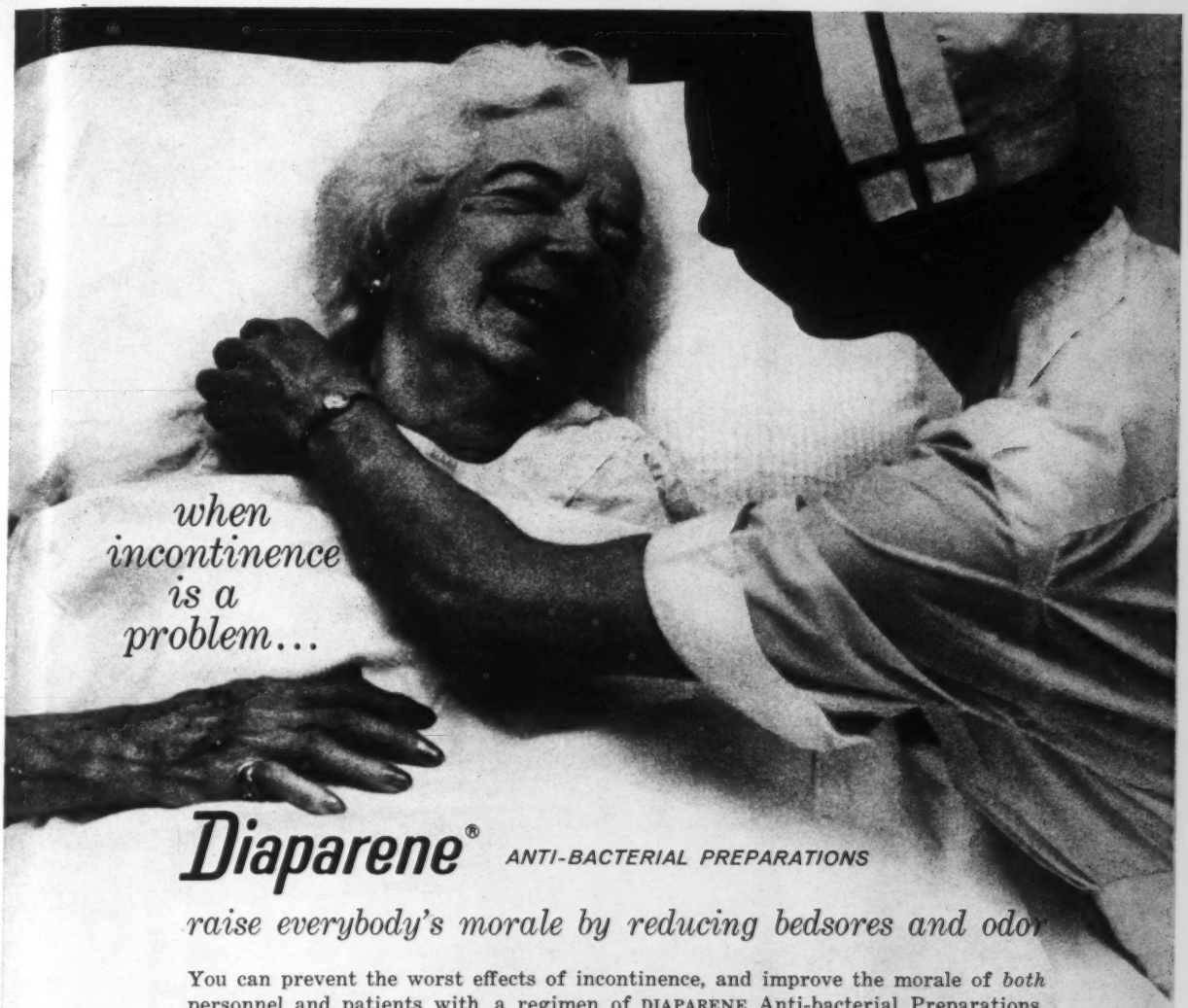
Meanwhile, the proceedings of the first conference should be required reading for anyone interested in mental retardation. Those engaged in psychiatry and allied disciplines, who have heard at one time or another that such a problem exists, should lose no time in acquainting themselves with the contents of this book.

BENEDICT NAGLER, M.D.

CURRENT STUDY

This column lists reports on investigations of interest to mental hospital personnel. Authors have agreed to make copies of this paper available, and requests should be sent to them directly, with 25¢ for postage and handling (unless otherwise indicated). The editor wishes to point out that this study has not been evaluated by the A.P.A.

EXAMINATION FOR STATE LICENSURE TO PRACTICE NURSING. Published by the American Nurses' Association, and developed by the Subcommittee to Study all the Various Aspects Relating to the State Board Test Pool Examination, this brochure gives authentic information regarding licensure to practice nursing. It explains why licensure is necessary and what the nurse gains from it, how the board of nursing functions as a unit of state government, and what its responsibilities are. Details are given on the method of preparing and administering the State Board Test Pool Examination. The process of interstate licensure is described, and information is given regarding licensure of nurses from other countries. Names and addresses of all boards of nursing are listed. Copies of this booklet may be obtained from the A.N.A., 10 Columbus Circle, New York 19, N. Y., at a cost of 5¢ each for quantities of 1-50; 4¢ for 51-100; 3¢ for over 100 copies.



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*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals *33*:61 (June 1) 1959.

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1. Rappaport, J.: Cur. M. Dig. *25*:57-62 (Nov.) 1958. 2. Fox, V., and Smith, M.A.: Quart. J. Stud. Alcohol. *20*:767-780 (Dec.) 1959.

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SPARINE

Promazine Hydrochloride

SPARINE is effective in the management of alcohol-induced syndromes, such as delirium tremens, acute hallucinosis, acute tremulousness and inebriation, as well as the withdrawal symptoms of drug addiction. SPARINE effectively controls central nervous system excitation, allays apprehension and anxiety, calms the agitated patient and is a useful adjunct to the management of mental and emotional disturbances. Both acute and chronic psychiatric illnesses respond to SPARINE therapy. SPARINE has been found to be useful in the management of nausea and vomiting of either central nervous system or gastric reflex origin. SPARINE effectively facilitates the action of analgesics and central nervous system depressants.

SPARINE may be used as an aid in diagnostic and therapeutic regimens. Such nonspecific symptoms as anxiety, pain, vomiting, nausea and hiccups frequently make more difficult both diagnosis and therapy of organic disease. SPARINE allays such symptoms without masking physical, neurological or laboratory findings.

DIRECTIONS. For maximal therapeutic benefit the amount, route of administration and frequency of dose should be governed by the severity of the condition treated and the response of the patient. Oral administration should be used whenever possible, but when nausea, vomiting or lack of cooperation is evident, SPARINE should be given intravenously or intramuscularly. SPARINE *when used intravenously should not exceed a concentration of 25 mg. per cc.; injection should be given slowly.* Dilute 50 mg. per cc. concentration with equivalent volume of physiological saline before I.V. use. Avoid injection around or into the wall of the vein.

Alcoholism, other Mental and Emotional Disturbances. In the management of agitated patients, SPARINE should be given I.V. in initial doses of 50 to 150 mg. If the desired calming effect is not apparent within 5 to 10 minutes, additional doses up to a total of 300 mg. may be given. Once the desired effect is obtained, SPARINE may then be given I.M. or orally in maintenance doses of 10 to 200 mg. at 4 to 6 hour intervals. *In less severe disturbances,* initial oral therapy may be satisfactory. When tablet medication is unsuitable or refused, SPARINE Syrup may be used. IN THE ACUTELY INEBRIATED PATIENT the initial dose should not exceed 50 mg. to avoid further depressant effect of alcohol.

As an Antiemetic. Usual dose is 25 to 50 mg. repeated at 4 to 6 hour intervals. When oral route is not feasible, 50 mg. I.V. or I.M. will usually control the symptom, but oral medication should be initiated as soon as feasible.

PRECAUTIONS. Although rare, drowsiness, dizziness and transitory postural hypotension may occur. If a vasopressor drug is indicated, norepinephrine is recommended since SPARINE reverses the effect of epinephrine. Agranulocytosis has been reported in only 18 cases in about 3½ million patients. If, however, signs of cellular depression—sore throat, fever, malaise—become evident, discontinue SPARINE, check white blood cell count, and initiate antibiotic and other suitable therapy if indicated. Seizures, reported as occurring during SPARINE therapy, occur usually with rapid large increases in dose and at a daily dosage above 1 Gm. Caution must be exercised when administering SPARINE to patients with a history of epilepsy. Avoid perivascular extravasation or intra-arterial injection, as severe chemical irritation or inflammatory response may result. Because of its facilitating action on analgesics and central nervous system depressants, give them in reduced dosage with SPARINE. Do not use in comatose states due to central nervous system depressants (alcohol, barbiturates, opiates, etc.). Use with caution in patients with cerebral arteriosclerosis, coronary heart disease, or other conditions where a drop in blood pressure may be undesirable.

For further information on prescribing and administering SPARINE *see descriptive literature, available on request.*

NEWS & NOTES

Senate Subcommittee Scrutinizes Patients' Constitutional Rights

A PERSON WHO HAS BEEN COMMITTED to a mental hospital because he is in need of treatment has a constitutional right to receive such treatment, said Dr. Morton Birnbaum, a general practitioner and an attorney of New York City, testifying in March before the U. S. Senate Subcommittee on Constitutional Rights. A person who has been robbed of his liberty solely because he is mentally ill is entitled to receive adequate medical care so that he may regain his health, and therefore his liberty, as soon as possible.

". . . the courts must be prepared to hold that if an inmate is being kept in a mental institution against his will," continued Dr. Birnbaum's testimony, "he must be given proper medical treatment or else . . . obtain his release at will in spite of the existence or severity of his mental illness. If an inmate were to apply for a writ of habeas corpus to obtain his release, among the issues that he could raise . . . could be the questions of whether or not the formal procedures . . . were complied with . . . whether or not he is sufficiently mentally ill to require institutionalization and whether or not he is being given adequate treatment for his mental illness. . . ."

When the late Senator Thomas C. Hennings, Jr. (D., Mo.) then chairman of the subcommittee, announced the hearings, he stated that the task was to determine the extent to which the constitutional rights of mentally-ill persons, including the right to due process, are being observed under present-day statutes and legal procedures.

More than 20 witnesses testified, some representing organizations, while others appeared simply as interested citizens. Among those appearing were Drs. Francis J. Braceland and Jack R. Ewalt, representing the A.P.A.; Drs. Lauren H. Smith and Zigmond Lebensohn, representing the A.M.A. Council on Mental Health; Dr. John J. Blasko, representing the Veterans Administration; as well as Drs. Winfred Overholser, Manfred Guttmacher, Thomas Szasz, C. H. Farrell, Eugene Hargrove; Judge Stephen S. Chandler, Okla., Chairman of the American Bar Foundation's Committee on Procedures in Hospitalization and Discharge of the Mentally Ill.; Judge John Biggs, Jr., of the U. S. Court of Appeals, testified for the American Bar Association.

QUARTERLY CALENDAR

A.P.A. ANNUAL MEETINGS

1961 May 8-12, Morrison Hotel, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Sheraton-Fontenelle Hotel, Omaha, Neb. (13th)
1962 Sept. 25-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel America, Boston, Mass. (16th)

OTHER PROFESSIONAL MEETINGS

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, Annual Meeting, *May 12*, Morrison Hotel, Chicago, Ill.

CANADIAN PSYCHIATRIC ASSOCIATION, Annual Meeting, *June 4-10*, Queen Elizabeth Hotel, Montreal.

WORLD CONGRESS OF PSYCHIATRY, *June 4-10*, Queen Elizabeth Hotel, Montreal. (Inq. Allan Memorial Institute, 1025 Pine Ave. West, Montreal 2, P.Q.)

SOCIETY OF BIOLOGICAL PSYCHIATRY, Annual Convention & Scientific Program, *June 9-11*, Claridge Hotel, Atlantic City, N. J.

AMERICAN GERIATRICS SOCIETY, Annual Meeting, *June 22-23*, The Waldorf-Astoria, New York City. (Inq. Dr. R. J. Kramer, Sec., 2907 Post Rd., Warwick, R. I.)

AMERICAN MEDICAL ASSOCIATION, Annual Meeting, *June 26-30*, New York City.

INTERNATIONAL MEDICAL CONFERENCE ON MENTAL RETARDATION, *early July*, Vienna, Austria. (Inq. Dr. Ella Yanger, Div. Maternal & Child Health, State House, Augusta, Maine.)

ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION, Annual Meeting, *July 4-7*, Belfast, Northern Ireland.

AMERICAN ASSOCIATION FOR REHABILITATION THERAPY, Annual Meeting, Scientific and Clinical Conference, *July 10-14*, Indiana Univ. Medical Center and Sheraton-Lincoln Hotel, Indianapolis, Ind.

INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION, Congress, *July 30-August 3*, Edinburgh, Scotland. (Inq. Hon. Sec., 37 Albion St., Hyde Park, London, England.)

INTERNATIONAL CONGRESS OF PSYCHOTHERAPY, *August 21-26*, Vienna, Austria. (Inq. Dr. W. Speil, Lazarettgasse 14, Vienna 9, Austria.)

INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY, *August 24-27*, Paris, France. (Inq. Dr. W. J. Warner, P.O. Box 819, Grand Central Sta., New York 17, N. Y.)

WORLD FEDERATION FOR MENTAL HEALTH, International Congress on Mental Health, *August 30- September 5*, Paris, France. (Inq. Secretary General, WFMH, 19 Manchester Street, London W.1, England.)

AMERICAN PSYCHOLOGICAL ASSOCIATION, Annual Convention, *August 30-September 6*, New York, N. Y.

"It would be a great boon to the advancement of the treatment and care of the mentally ill in America if some national influence could be brought to bear that would encourage the states to develop more uniform laws that more nearly reflect the medical view of a citizen's *right to treatment*," read part of the testimony of Drs. Ewalt and Braceland. They went on to quote a statement made in 1869 by Dr. Isaac Ray:

"In the first place put no hindrance in the way to prompt use of those instrumentalities which are regarded as the most effectual in promoting the comfort and restoration of the patient. Secondly, it should spare all unnecessary exposure of private troubles and all unnecessary conflict with popular prejudices. Thirdly, it should protect individuals from wrongful imprisonment. It would be objection enough to any legal provision that it failed to secure these objects in the completest possible manner."[1]

One of the few points upon which most witnesses agreed was that it is never desirable to detain a disturbed person even briefly in a jail. If no psychiatric facilities are available, some other alternative must be found, and immediate steps taken to provide the necessary facility. There was a good deal of discussion as to whether the use of police and police vehicles to take a patient to the hospital is appropriate; who, other than a psychiatrist, is qualified to sign or execute a certificate of commitment; and whether it is better to commit a patient to the hospital for a definite or an indefinite period.

Occasionally, it seemed that the patient's constitutional rights were actually in conflict with his medical needs. The concensus of legal opinion, for instance, was that the patient has a right to receive notice of a pending commitment proceedings, while some psychiatrists considered this could have a traumatic effect upon a mentally disturbed person. Witnesses were in general agreement, however, that neither the patient's mental condition nor whether he attends the proceedings should prejudice his constitutional right to have legal counsel at a judicial hearing concerning his commitment or release.

[1]*Ray, Isaac: Confinement of the Insane, American Law Review* 3:208 (*Jan.*) 1869.

The question of the "constitutional right" of a patient to be treated if he has been committed to a hospital on account of mental illness was debated. A suggestion was made that this "right" might be tested by a suit.

The ever-thorny problem of privileged communication between doctor and patient was raised, as well as that of the hospital patient's right to receive and make telephone calls and to receive and write letters without restriction.

Coming as they did at a time when the recommendations of the Joint Commission on Mental Health and Illness are before Congress, and when ACTION FOR MENTAL HEALTH, as the report is called, has been placed on the bookstalls, these hearings are of vital interest. One of the recommendations of the Joint Commission is that an expert committee should assist in bringing about changes in state laws to ensure that patients receive treatment as well as care, and that voluntary admission become the preferred method. Senator Sam. J. Ervin (D., N. C.) the present Chairman of the subcommittee, expressed the hope that as a result of these hearings model laws would be enacted for the District of Columbia. There is no doubt but that laws enacted for federal jurisdictions would have great influence over future state legislation.

Attention, Canadian Subscribers!

The Canadian Film Institute is now making available the popular film *Natural History of Psychotic Illness in Childhood* for a rental fee of $7. Those interested should write to the Canadian Film Institute, 1762 Carling Avenue, Ottawa 3, Ontario.

Business Administrators Meet

RICHMOND, INDIANA, April 4—The board of governors of the American Society of Mental Hospital Administrators held their annual spring meeting at Richmond State Hospital. Attending the 4-day conference were, left to right, seated: Delbert Mesner, Nebraska Psychiatric Institute, Omaha, Neb.; Charles O'Connell, Middletown, N. Y., Treasurer; Carl Yopp, Little Rock, Ark., President-Elect; Roy Purser, Raleigh, N. C.; Fred Matheson, Essondale, B. C.; and standing: William Brenizer, Richmond, Ind., Secretary; Alexis Tarumianz, Farnhurst, Del., Board Chairman; Joseph Greco, St. Louis, Mo., President; Jim Hodges, Lansing, Mich., Governor-at-Large; Rod Clelland, Phoenix, Ariz.; and Dr. J. Klepfer, Superintendent of Richmond State Hospital.

The board discussed the development of business administration in psychiatric institutions as a career service, the advancement of standards for improving the efficiency of business administration, and plans for conducting educational workshops.

A suggestion by MENTAL HOSPITALS that the society help with the development of business administration articles was referred to the society's editorial committee for action.

The group also formulated a program for the third annual meeting of the society in October in Omaha, Neb., based on the discussion of future educational aims and criteria for testing hospital supplies and equipment.

Research & Training Vital, Psychiatrists Tell Subcommittee

"We believe a nation is rendered vulnerable by harboring within itself large numbers of disturbed and retarded citizens who are neglected only because the resources are not made available for their care," declared Dr. Jack R. Ewalt in his testimony before the House Appropriations Subcommittee on Labor, Health, Education, and Welfare, under the chairmanship of Rep. John E. Fogarty (D., R.I.) on April 18. Dr. Ewalt, with Dr. Francis J. Braceland, was representing the A.P.A. in support of appropriations for the National Institute of Mental Health. Dr. Ewalt went on to tell the subcommittee:

"The money requested for the N.I.M.H. for 1962 is substantial in sum, but in comparison with our national wealth it is not so impressive; it is less than 50 per cent of our 1958 expenditure for power lawn mowers and less than 25 per cent of our expenditure for candy, nuts, and confections (U. S. Department of Commerce, 1959). Surely a nation so rich that it can extend aid to all corners of the world can also afford to properly care for the sick and afflicted among its own citizens. Tooling up for this care requires continued expansion of our research and training facilities."

Dr. Braceland pointed out that one of the principal recommendations of the final report of the Joint Committee on Mental Illness and Health is the continued, additional support for mental health research. He said that the report would be the blueprint for mental health programs for at least the next ten years. The report is now before Congress.

"I do not believe there is any need for other surveys for a long time to come," he added. "The pressing need is to implement the findings of this group, for it will redound not only to the benefit of the sick and their families, but also to the welfare of the nation."

South African Physician Talks to A.P.A. Staff

As part of their ongoing educational program, staff members of the A.P.A. Central Office recently heard an interesting talk about psychiatry in South Africa. Dr. Lynn Gillis, senior psychiatrist at Tara Hospital for Nervous Diseases at Johannesburg, described this unusual hospital which is the only therapeutic community in South Africa. The hospital's program closely follows Dr. Maxwell Jones' concept of the therapeutic community, but varies from it when necessary to meet local needs. The hospital is associated with the Medical School of the University of Witwatersrand.

Dr. Gillis is on a three-months' WHO Fellowship, visiting psychiatric facilities in Canada and the United States. He expects to return to Johannesburg in the fall, and has promised to prepare a paper on the Tara program for publication in MENTAL HOSPITALS.

PEOPLE & PLACES

WASHINGTON, D. C.: **Dr. William F. Sheeley,** chief of the A.P.A. General Practitioner Education Project, has been appointed to the Editorial Board of PSYCHOSOMATICS, the official journal

of the Academy of Psychosomatic Medicine.

Dr. Fritz A. Freyhan is the new deputy chief of Neuropharmacology Research Center at St. Elizabeths Hospital.

VIRGINIA: **Dr. Rex Blankinship** was elected president of Westbrook Sanitarium, Inc., in Richmond, upon the retirement of **Dr. Paul V. Anderson. Dr. John R. Saunders** became its medical director, and **Dr. T. F. Coates, Jr.,** assistant medical director.

Lynchburg Training School has a new clinical director. He is **Dr. Ilhan Nuraltay,** former chief of physical medicine and rehabilitation and director of research and training. **Dr. Jack E. Botton,** a neurosurgeon in part-time private practice, was appointed to succeed Dr. Nuraltay as director of research and training.

PENNSYLVANIA has three new schools for the mentally deficient. They are: 1) **Hamburg State School and Hospital,** 954 beds—Don Longfellow, M.D., Superintendent; 2) **Ebensburg State School** (annex of Polk State School), 123 beds—A. B. Sigmann, M.D., Physician-in-Charge; 3) **Pennhurst State School Annex** at White Haven, 376 beds—Leopold A. Potkonski, M.D., Superintendent.

HERE & THERE: Compton Sanitarium, Compton, Cal. (G. Creswell Burns, M.D., Supt.) will from now on be known as the **Compton Foundation Hospital.**

Dr. John G. Freeman resigned as instructor of psychiatry at the Nebraska Psychiatric Institute, Omaha, to become superintendent of the Montana State Hospital at Warm Springs.

Dr. Rudolph Depner, the assistant commissioner of the Maryland Department of Mental Hygiene since 1957, has moved to Wisconsin to become medical director of the Milwaukee County Asylum.

Dr. Joseph Marcovitch recently resigned his position as superintendent of the Jacksonville State Hospital, Illinois, to resume his service with the Veterans Administration. He is now director of professional services at the VA Hospital in St. Cloud, Minn.

Oregon recently opened a new state hospital at Wilsonville, the **Dammasch State Hospital.** The $9-million, 460-bed intensive psychiatric center will serve patients from the greater Portland area. It will operate as an open hospital under the superintendency of **Dr. Russell L. Guiss,** with the main concern on prevention of "demotivation" by an active treatment program and early predischarge planning. A screening clinic, and outpatient and daytime hospital services will also be provided. **Dr. Hans Fink** has been named director of the clinical section.

HONORS: On March 2, the Junior Chamber of Commerce of Washington, D. C., presented the annual Melvin C. Hazen Award to **Dr. James S. Costa,** as the "outstanding young man in District Government." Dr. Costa, a 33-year-old psychiatrist on the staff of the District of Columbia General Hospital, was nominated for his outstanding development and coordination of the rehabilitation program for narcotic addicts at the hospital.

Upon his retirement as Surgeon General of the Navy, **Dr. Bartholomew W. Hogan,** the new A.P.A. assistant medical director, was awarded the Distinguished Service Medal by President Kennedy.